BRAIN INJURY WAIVER

7/12/2016

1115 Demonstration Application

Submitted to:

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

Submitted by:

State of Michigan

Governor Snyder

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1115 DEMONSTRATION APPLICATION

INTRODUCTION

Michigan is committed to providing high quality services and supports to residents who have suffered a brain injury. The Michigan Department of Health and Human Services (MDHHS) is pleased to present Michigan's Brain Injury Waiver (BIW). The BIW provides necessary services and supports to persons suffering qualifying brain injuries who, but for the provision of these services, would otherwise be served in an institutional setting. The program provides critical brain injury-specific rehabilitation and support in the post-acute injury period with the goal of assisting the participant in becoming capable of living in the most independent setting.

SECTION I – PROGRAM DESCRIPTION

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

The Brain Injury Waiver focuses on specialized rehabilitation and supportive services required upon release from an acute care setting following a moderate or severe brain injury. These services are for participants who can benefit from the advanced level of rehabilitative therapies and other services offered. Specialized rehabilitation services can be obtained in the following settings: transitional residential (TR), outpatient, or home and community-based (HCB). All providers for BIW services must have appropriate accreditation, certifications, or specialized training in serving individuals with brain injuries.

Appropriate accreditation, certifications, or specialized training include:

- Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) with:
    - Medical Rehabilitation certification for inpatient services,
    - Medical Rehabilitation certification for outpatient services, or
    - Medical Rehabilitation certification for both inpatient and outpatient services
- Medicare and Medicaid certification as Comprehensive Outpatient Rehabilitation Facility (CORF)
- Medicare accreditation as a Rehabilitation Agency or Outpatient Physical Therapy program as verified by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- In areas of the state where there is limited or no access to CARF, CORF, or AAAASF accredited or certified providers with additional accreditation or certification in Brain Injury, MDHHS may allow individual providers who are certified as Brain Injury Specialists (CBIS) through the Brain Injury Association of America's Academy of Certified Brain Injury Specialists (ACBIS) and who work in a health care program with additional licensing or accreditation to become brain injury providers.

BIW has the capacity to serve up to 100 individuals aged 21 and older during the fiscal year with an initial budget of approximately $2.5 million for the first year of the program. Twenty of the 100 program enrollments are reserved to ensure capacity to serve participants in a TR rehabilitation setting. Upon completion of rehabilitation, participants who require additional brain injury specific services to build upon or maintain skills developed will receive home and community-based services (HCBS). Not all BIW participants will require the transitional residential rehabilitation. Transitional residential, outpatient, and HCB services will be available to individuals upon enrollment.

MDHHS will prioritize enrollment for the BIW as follows:

1) Applicants who otherwise qualify for BIW enrollment, are receiving brain injury specific services through the early and periodic screening, diagnosis, and treatment (EPSDT) program, and will age-out of the EPSDT program before completing brain injury specific treatment and other services will receive priority for enrollment. Usually this occurs upon the applicant's 21st birthday. It is necessary to provide priority to these individuals so that their treatment is not interrupted by a birthday and to assure the best success for regaining independence. Brain injury specific services are not otherwise available to this population.

2) Applicants suffering a brain injury that is traumatic in nature will receive priority for enrollment over applicants with an acquired brain injury to maximize available resources. For the purposes of this demonstration, traumatic and acquired brain injuries are defined as follows:

    a. A traumatic brain injury (TBI) is defined as a blunt force trauma to the brain. The Center for Disease Control defines a traumatic brain injury as "caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain." Injuries such as gunshot wounds, falls or motor vehicle accidents involving injuries to the head are considered TBIs. Explosive blasts can also cause a TBI, particularly among those who serve in the U.S. military.
    b. An acquired brain injury (ABI) is an injury to the brain, which is not hereditary, congenital degenerative, or induced by birth trauma. Acquired brain injuries occur after birth, but are not caused by an external force and are non-traumatic. Examples of acquired brain injuries include stroke, near drowning, substance abuse overdose, hypoxic or anoxic brain injury, tumors, neurotoxins, electric shock, or lightning strike.

    A brain injury does not include damage to the brain resulting from neurodegenerative disorders, such as Alzheimer's disease, dementia, etc.

3) Applicants closest to their eighteen months post injury date will have priority over those with a more recent injury. This prioritization is necessary to assure individuals do not exceed the eighteen months post injury window for BIW enrollment.

BIW participation is limited to two years per enrollment for each individual. Individuals previously served by the BIW who have suffered a new brain injury may reapply for and reenroll in the program. Discharge from the program will be based upon the individual meeting any of the following criteria:

- The individual is not eligible for Michigan Medicaid
- The individual died
- The individual is not amenable to treatment
- The individual is non-compliant with program or facility rules
- The individual has been institutionalized in a hospital or nursing facility for more than 30 days
- The individual enrolled in a hospice program
- The individual moved out of the program service area
- The individual has not shown progress for at least 30 days while enrolled in the program
- The individual chose to disenroll
- The individual transferred to another program and no longer requires BIW services
- The individual no longer meets program criteria
- The individual refused to accept program services
- The individual met program goals as established in the person-centered plan

All participants will develop a program discharge plan as a part of their person-centered plan. The discharge plan will be altered as necessary based upon the individual's goals and outcomes. Individuals who are within the last six months of their twenty-four month BIW enrollment period will begin intensive discharge planning. These individuals will most likely need to be transitioned to other home and community-based services programs. The last six months of BIW enrollment will include planning for enrollment in the most appropriate program for the individual based upon their choice and eligibility for other programs. Every effort will be made to assure a smooth transition out of the BIW program and into other Long Term Supports and Services (LTSS) programs, as needed, without a lapse between BIW and other program enrollment.

2) Include the rationale for the Demonstration.

The purpose of this Demonstration is to reduce nursing facility recidivism for individuals with a qualifying brain injury and increase long-term functioning, independence and quality of life for program participants. It is designed specifically to address the needs of individuals suffering qualifying brain injuries who may benefit from the services and supports in this Demonstration. Without specialized post-acute rehabilitation, individuals with brain injuries often do not show improvement in these areas. Studies have found that with specialized post-acute rehabilitation, up to 80% of individuals with a brain injury can return to work (Malec JE, 1996). Providing intensive services that will improve independence, functionality, and quality of life will lower the individual's dependence upon LTSS over their lifetime.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

Hypothesis 1: Individuals participating in the BIW program will demonstrate successful rehabilitation outcomes.

Evaluations:

- At least 75% of the BIW participants who complete their person-centered rehabilitation services will demonstrate improvement in their functional ability.
- At least 75% of the BIW participants will achieve 75% of their individual rehabilitation goals after one year of enrollment or upon discharge from the program, whichever comes first.

Hypothesis 2: BIW participants will demonstrate increased independence and community participation.

Evaluations:

- At least 75% of the BIW participants will report increased independence with or without the use of compensatory strategies to address deficiencies in thinking, memory, learning, coordination and balance, senses (speech, hearing vision), or emotions.
- At least 75% of the BIW participants will report increased community participation at each assessment, or at least every six months during enrollment in the BIW.

Hypothesis 3: Total annual Medicaid costs for BIW participants will be less than the costs of services had the participants received institutional care.

Evaluation: Aggregate annual Medicaid costs for BIW participants will be less than the Medicaid costs for a comparable group of beneficiaries receiving institutional care.

Hypothesis 4: BIW participants will report increases in quality of life during their enrollment in the BIW.

Evaluation: BIW participants will report improved quality of life at each assessment, or least every six months during enrollment in the BIW.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

The BIW Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration.

The proposed timeframe for this Demonstration is five years, beginning January 1, 2017 and operating through December 31, 2021.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The Demonstration will not affect or modify other components of Michigan's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

SECTION II – DEMONSTRATION ELIGIBILITY

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Individuals Receiving SSI	1902(a)(10)(A)(i)(II)(aa) 42CFR 435.120	No income limit
Individuals Receiving Mandatory State Supplements	42 CFR 435.130	No income limit
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)	0 – 100% of the FPL
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii)	100 – 120% of the FPL
Qualifying Individuals	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)	121 – 135% of the FPL

Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Independent Foster Care Adolescents (for ages 21-26)	1902(a)(10)(A)(ii)(XVII) 1905(w)	No income limit
Individuals Receiving Home and Community-Based Services under Institutional Rules	42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	0 – 300% of the FBR
Optional State Supplement Recipients – 1634 States, and SSI Criteria States with 1616 Agreements	1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	No income limit
Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) 1902(m)(1)	0 – 100% of the FPL
Individuals Eligible for Home and Community-Based Services	1902(a)(10)(A)(ii)(XXII) 1915(i)	0 – 300% of the FBR

Individuals for Home and Community-Based Services – Special Income Level	1902(a)(10)(A)(ii)(XXII) 1915(i)	0 – 300% of the FBR
Individuals at or below 133% FPL Age 19 through 64	1902(a)(10)(A)(i)(VIII) Early implementation option	0 – 133% of the FPL

Medically Needy Populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Medically Needy Parents and Other Caretaker Relatives	1902(a)(10)(C) 42 CFR 435.310	Parents: 0 – 135% of the FPL Caretaker Relatives: 0 – 54% of the FPL
Medically Needy Aged	1902(a)(10)(C) 42 CFR 435.320 and 435.330	0 – 100% of the FPL
Medically Needy Blind	1902(a)(10)(C) 42 CFR 435.322 and 435.330	0 – 100% of the FPL
Medically Needy Disabled	1902(a)(10)(C) 42 CFR 435.324 and 435.330	0 – 100% of the FPL

Additional BIW Admission Criteria:

MDHHS will evaluate the criteria listed below for each person with a brain injury who applies for the Brain Injury Waiver. All applicants for the BIW must meet each criterion at the time of application. MDHHS will not consider individuals who do not meet all criteria specified below for enrollment in the BIW.

1. The individual has active Michigan Medicaid eligibility, or has all of the following:

    a. A completed Michigan Medicaid application with all necessary verifications submitted to the MDHHS Field Office awaiting review, and
    b. Reasonable assurance the MDHHS Field Office will likely approve the submitted application, and
    c. The MDHHS Field Office has registered the application on Bridges, as verified by MDHHS staff.

2. Medical records from the acute or institutional care setting, hereafter referred to as “care setting”, immediately prior to application for the BIW must demonstrate all of the following:

    a. The injury occurred no more than 18 months before the BIW admission date or start of BI-specific services through the EPSDT program.
    b. The individual is at least 21 years old.

c. The individual has been determined to have a significant functional or cognitive impairment as identified by a comprehensive assessment and must require long-term support services.
d. The individual must have functional or cognitive limitations that are a direct result of a brain injury as documented by a physician, neuropsychologist, or other qualified health professional.
e. The individual has the ability to maintain new memory, including skills learned at the setting such as coping mechanisms or other techniques to compensate for identified functional or cognitive deficits.
f. The individual does not require continuous one-on-one attention to remain free from harm within the care setting.
g. The individual is willing and able to participate in targeted brain injury therapies and the person-centered plan developed after enrollment.
h. The individual does not exhibit behavior that seriously jeopardizes the health, safety, and welfare of themselves or others.
i. The individual is not at high risk of elopement.
j. The individual has not used illegal or abused legal substances in the care setting, or at home after discharge from the last treatment facility.

3. Individuals who, at the time of application, are no longer in an acute or institutional care setting must furnish or provide access to medical records that demonstrate the criteria specified in #2 above, either from the prior care setting, or from a current qualified health care professional. Additionally, these individuals must continue to demonstrate they meet the criteria specified in #2 above at the time of application, as documented by a qualified health care professional.

4. Because of the limited scope of the BIW, and the availability of other resources for individuals with the conditions listed below, the BIW will not serve individuals with the following diagnoses, diseases, or conditions that are directly related to or are the cause of their brain injury:

   a. Stroke, cerebral vascular accidents, or transient ischemic accidents
   b. Aneurism or other brain bleed
   c. Complications from diabetes, such as a lack of or too much insulin
   d. Cardiac arrest or myocardial infarction
   e. Alzheimer’s disease and similar neuro-degenerative diseases, the primary manifestation of which is dementia
   f. Individuals whose functional and cognitive limitations are due **<u>solely</u>** to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, the aging process, or individuals with deteriorating

diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State.

There are no changes to the standards and methodologies used to determine eligibility.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

N/A

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

The projected number of individuals who would be eligible for the BIW is 100 per fiscal year. Projections are not based on current state programs.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

Michigan will use spousal impoverishment rules under section 1924 of the Act to determine eligibility of individuals with a community spouse. Allowance for the personal care needs of the participant is 300% of SSI, equal to the special income level for institutionalized persons. Allowance for the personal needs of a participant with a community spouse is the same as the amount used for the individual's maintenance allowance. Michigan uses the same reasonable limits as are used for regular (non-spousal) post-eligibility for incurred medical or remedial care expenses not subject to payment by a third party.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority.

N/A

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014, or in light of other changes in 2014.

N/A

SECTION III – DEMONSTRATION BENEFITS AND COST SHARING REQUIREMENTS

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☒Yes ☐No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☐Yes ☒No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration.

N/A

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

N/A

5) In addition to the Benefit Specifications and Qualifications form, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Beneficiaries enrolled in the BIW will have access to all applicable Medicaid State Plan services with the following exceptions:

- Hospice services
- Pregnancy-related services
- Physical, Occupational, and Speech language pathology therapy services

Hospice services are excluded as they would be contrary to the goal of rehabilitation. Pregnancy-related services are excluded because individuals who are pregnant should delay enrollment in the BIW until the pregnancy is resolved. The brain injury specific therapies offered through the BIW differ in scope, intensity, and provider type from Medicaid State Plan therapies as described in Section VI. Provision of both types of therapies would be a duplication of services.

6) Indicate whether Long Term Services and Supports will be provided.

☒Yes (if yes, please check the services that are being offered) ☐No

The LTSS provided in the BIW are:

- Targeted BIW Case Management
- Environmental Accessibility Adaptations
- Community Transition Services
- Supported Employment
- Other:
    - Brain Injury Day Treatment Program
    - Brain Injury Transitional Residential Rehabilitation Services
    - Brain Injury Home and Community-Based Rehabilitation Services
    - Specialized Medical Equipment, Supplies, and Assistive Devices
    - Prevocational Services
    - Counseling

Additional information related to LTSS is found in Attachment A of the application. Additional information regarding the services listed above is found in Attachment B of the application.

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

Premium assistance for employer sponsored coverage will not be available through this Demonstration.

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

N/A

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.

N/A

10) Indicate if there are any exemptions from the proposed cost sharing.

N/A

SECTION IV – DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan.

☒ Yes

☐ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

Michigan has a robust brain injury provider network because of our unique auto no fault law. The BIW will allow Medicaid beneficiaries who have suffered a qualifying brain injury access to this delivery system. This is an important extension of Medicaid services because other than the auto no fault services, very few, if any, insurance, programs, or funding are available to assist with the cost of brain injury rehabilitation beyond the acute care phase. Because of the intensity and specialization required for providers to understand and treat brain injuries, the cost of these intensive services is prohibitive for those who qualify for Medicaid. This means that often once individuals are stable, they are sent home or to a nursing facility and do not receive the services needed to maximize their independence and restart their lives.

Providing Medicaid beneficiaries access to these services will result in a lower cost of services and supports throughout the individual's lifetime by allowing the participant to receive the services and supports needed to rebuild their life after their injury and learn the skills needed to regain their independence, including reentering the workforce. Additionally, the BIW includes services and supports needed to reinforce the skills learned during therapy to assist individuals with retention. Teaching and reinforcing the skills needed to maximize independence will improve not only the individual's health status, but also their quality of life. Assuring that BIW participants are linked to the LTSS needed after meeting their goals within the BIW will assist the individual with maintaining that quality of life long after enrollment in the BIW.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

☐ Managed care

- ☐ Managed Care Organization (MCO)
- ☐ Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)

☒ Fee-for-service (including Integrated Care Models)
☐ Primary Care Case Management (PCCM)
☐ Health Homes
☐ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

N/A

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

N/A

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

N/A

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

N/A

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

N/A

e) Describe how the managed care providers will be selected/procured.

N/A

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

The proposed delivery system will only include the brain injury specific services and providers as indicated in Section III.6 and Attachments A and B. The BIW delivery system will consist specifically of providers focused on furnishing services to individuals with brain injuries. Because of Michigan's unique Auto No Fault provisions, there is currently a robust delivery system for brain injury specific services. The BIW will utilize the expertise of this well-developed delivery system to furnish BIW services. All BIW participants will be eligible to receive Medicaid State Plan services using established delivery systems, with the exception of those services listed in Section III.5. However, the established delivery systems for Medicaid State Plan services do not currently include providers who specialize in

brain injury treatments and services, since the services they provide have not been within the scope of the Michigan Medicaid program.

The BIW will not offer self-determined services. The reason for not offering this option is that brain injuries often cause impulsive behavior, attentional deficits, aggressiveness, and vulnerability to the redirection of others. With these symptoms, participants often lack the ability to make sound decisions about hiring, firing, and training staff. Additionally, participants are often unable to determine the motives of others and this could leave them vulnerable to abuse, neglect, and exploitation by untrustworthy caregivers.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

☐Yes ☒No

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

See Attachment C.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

N/A

SECTION V – IMPLEMENTATION OF DEMONSTRATION

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Michigan’s proposed schedule is to implement the BIW statewide beginning January 1, 2017.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Referrals to the BIW may be made by acute care setting Case Managers, nursing facility social workers or family members of the potential BIW participant. Once a review of the required submitted documents has been completed, the Medicaid Agency decides if the potential BIW participant will be admitted or denied to the program. Documents required to be submitted include: Emergency room records, CT scan report of brain, neuro consults and surgery reports related to the brain injury, therapy notes, therapist evaluations, social worker evaluation, completed neuro-psychological evaluation, guardianship paperwork. Other documents relative to an individual may also be requested as needed. If approval for admission has been granted, the referring agency, potential BIW participant and authorized representative will receive written notification and a copy of the BIW Participant Handbook (see Attachment A for more information). If the Medicaid Agency decides the participant is not a candidate for the BIW, the applicant will receive an Adequate Action Notice from the Medicaid Agency that contains the reason for the denial and information about the Medicaid Fair Hearings process, including how to file a hearing request.

Once approval for admission to the BIW has been granted, the participant and authorized representative are given the option of where the participant will receive services. If Transitional Residential service is chosen, the participant and authorized representative will choose an approved provider. If receiving home and community-based services or outpatient BI specific therapies, the participant and authorized representative will choose the providers from which to receive BI services. The case manager or Medicaid Agency will assist the individual and authorized representative with making this choice as needed. The provider the participant chooses to enroll with will work with the participant and authorized representative to develop a person-centered plan of care within a week after BIW admission. All services must be documented in the plan of care and must be prior authorized by the Medicaid Agency.

For individuals who participate in a HCBS program in conjunction with the BIW, a coordinated person-centered plan of care will be developed by the participant and authorized representative with the case manager and representatives from the BIW and other HCBS program to assure there is no duplication of services and to assure the individual receives the services and supports needed to meet the goals identified in the plan of care. Other HCBS programs include the Home Help program, the MI Choice waiver, and MI Health Link.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement.

N/A

SECTION VI – DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every

demonstration application. The Budget Neutrality form and spreadsheet includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

See Attachment D, E and F.

SECTION VII – LIST OF PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

1) Provide a list of proposed waivers and expenditure authorities.

Title	Brief Description	Reference	Rational
Amount, Duration and Scope of Services	To enable the State to provide benefit packages to Demonstration populations that differ from the State plan benefit package	Section 1902(a)(10)(B)	Allows Michigan to offer unique services based on the waiver participants assessed needs that will enable the participants to maximize their independence and increase their quality of life after injury.
Comparability	To enable the State to provide BIW services to specific Medicaid-eligible individuals	Section 1902(a)(17)	Allows Michigan to target individuals with qualifying brain injuries for enrollment in the BIW.
Retroactive Eligibility	To enable the State to waive or modify the requirement to provide medical assistance for up to three months prior to the month of application	Section 1902(a)(34)	Allows Michigan to offer services to waiver participants upon enrollment in the waiver.
Reasonable Promptness	To enable the State to limit enrollment	Section 1902(a)(8)	Michigan has identified a very limited budget of $2,000,000 for the BIW at this time. Controlling enrollment allows Michigan to better manage limited financial resources.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

See chart above.

SECTION VIII – PUBLIC NOTICE

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

5) Comments received by the state during the 30-day public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

SECTION IX – DEMONSTRATION ADMINISTRATION

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title:	**Jacqueline Coleman, Waiver Specialist**
Telephone Number:	**(517) 241-7172**
Email Address:	**Colemanj@michigan.gov**

Michigan Brain Injury Waiver
Attachment A: Long Term Services and Supports Form

Please complete this form if you indicated in Section III that the Demonstration will provide long term services and supports (LTSS).

Indicate the Population(s) that the following long-term services and support description applies to:

Enter Populations Here:

Individuals aged 21 and over who have suffered a qualifying brain injury within 18 months of the date of admission to the Brain Injury Waiver and would benefit from program services.

Administration of the Long Term Services and Supports Program

Will the LTSS component of the Demonstration be operated by one or more State agencies other than the Medicaid agency?

☐Yes ☒No

If yes, please provide the contact information of the key contacts at those agencies, including name, title, name of agency, address, telephone number, email address and fax number. Also describe the specific sub-population associated with the contact:

Do other State agencies, that are not part of the Single State Medicaid Agency, perform Demonstration operational and administrative functions on behalf of the Medicaid agency?

☐Yes ☒No

Do any contracted entities, including managed care organizations, perform Demonstration operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if applicable)?

☐Yes ☒No

Do any local or regional non-state entities perform Demonstration operational and administrative functions?

☐Yes ☒No

If yes to any of the questions above, specify the types of State agencies, contracted entities and/or local/regional non-state entities and describe the specific functions that they perform. This includes individual enrollment, management of any enrollment or expenditure limits, level of care evaluation, review of service plans, prior authorization of services, utilization management, provider enrollment and agreements, rate

methodologies, rules, policies and procedures, and quality assurance and improvement activities. Please describe how the Single State Agency oversees the performance of these non-State entities:

Consolidation of Existing Waivers or Authorities into the Demonstration

Are existing State waivers or programs operating under other authorities are being consolidated into the Demonstration Program?

☐Yes ☒No

If yes, identify the existing waiver(s) (1915(b),(c),(d),(e) or State Plan authorities (1915(a), (i), (j), (k), 1932) that are being consolidated into the 1115 Demonstration, including the names of the waivers or programs and identifying waiver numbers. Also indicate the current status of these waivers or authorities. Describe how individuals in these programs will be transitioned to the 1115 Demonstration program and assured a comparable level of services, quality and continuity of care.

Level of Care to Qualify for the Program

This Demonstration is requested in order to provide LTSS to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which should be reimbursed under the approved Medicaid state plan:

Those that would otherwise be institutionalized in either a hospital or nursing facility. Hospital is defined in 42 CFR 440.10. Nursing facility is defined in 42 CFR 440.40 and 42 CFR 440.155.

Indicate and describe the level of care criteria for participants in the Long Term Services and Supports Demonstration program, such as hospital, nursing facility, ICF-MR, IMD-hospital, IMD-nursing facility, or needs-based criteria. Identify which entity performs the initial and subsequent level of care evaluations and the frequency of such reevaluations:

Hospital is defined in 42 CFR 440.10. Nursing facility is defined in 42 CFR 440.40 and 42 CFR 440.155.

Initial evaluations will be completed by the State Medicaid Agency. Reevaluations will be completed at least annually, or upon significant change in status by the State Medicaid Agency.

Individual Cost Limits
Do individual cost limits apply when determining whether to deny LTSS or entrance to the Demonstration to an otherwise eligible individual?

☐Yes ☒No

If yes, indicate the type of cost limit that applies and describe any additional requirements pertaining to the indicated limit:

☐ Cost Limit in Excess of Institutional Costs. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed the cost of a level of care specified for the Demonstration up to an amount specified by the State.

☐ Institutional Cost Limit. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

☐ Cost Limit Lower Than Institutional Costs. The State refuses entrance to the Demonstration to any otherwise qualified individual when the State reasonably expects that the cost of LTSS furnished to that individual would exceed an amount specified by the State that is less than the cost of a level of care specified for the Demonstration. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of Demonstration individuals.

Long Term Services and Supports – Outreach, Education, Enrollment and Screening
Describe the Demonstration program's approach to Outreach, Education, Enrollment and Screening, including any coordination with a Money Follows the Person program. Include a description of the roles of the State and other entities in the processes.

Outreach – The Medicaid Agency has informed potential providers of the BIW by including them in stakeholder meetings during the development of the waiver. The Medicaid Agency will continue to notify rehabilitation facilities, trauma centers, and other entities who may serve individuals with a brain injury through provider meetings, participation in conferences, the Medicaid Agency's website, and through the Brain Injury Association of Michigan.

Education – The Medicaid Agency will continue educating providers about the BIW as needed through attending provider forums, conferences, and other available avenues. The Medicaid Agency will provide contact information to receive additional information on its website and through pamphlets and brochures that may be developed for the program.

Enrollment – Qualified providers will submit required information to the Medicaid Agency through a web-based application. The Medicaid Agency staff will determine eligibility for enrollment in the BIW.

Screening – When interest in the program exceeds capacity, individuals will be screened for potential eligibility and placed on a waiting list according to the priority classification.

Person-Centered Planning

Indicate who is responsible for collaborating with the individual in developing the Demonstration's person-centered service plan and for its final development:

☒Case Manager ☐Social Worker
☒Other (please describe, include qualifications)

Family members, authorized representatives, therapists, and others as requested by the individual.

Supporting the Participant in Service Plan Development

Specify: (a) the supports and information that are made available to the individual (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the individual's authority to determine who is included in the process.

a) The Medicaid Agency or the referral agency provides the BIW Participant Handbook to all applicants during the enrollment process. The information packet explains the BIW services, the person-centered planning process, rights and appeals information, information on abuse, and other information relevant to brain injuries. The case managers solicit participant preferences for date, time, and place of the assessment meeting before finalizing schedules. The participant, the participant's chosen allies, family, and authorized representatives are provided with written information about the right to participate in the person-centered planning process upon enrollment in BIW, during assessment, reassessment, or upon request. The case manager provides additional information and support and directly addresses issues and concerns the participant may have either over the phone or in a face-to-face meeting. The initial person-centered planning meeting occurs in person at a location preferred by the participant and at a date and time chosen by the participant. Continued assistance from a case manager is available throughout the service planning process.

b) The participant has authority to determine who will be involved in the person-centered planning process and may choose allies, such as family members, friends, community advocates, service providers and independent advocates to participate. If preferred by the participant, a pre-planning conference may occur before the person-centered planning meeting. In this pre-planning conference, the participant and the case manager discuss who the participant wants to involve in the planning process, goals and dreams that will be addressed, topics that will be discussed at the meeting and topics that will not be addressed. The time and location for the planning meeting may also be determined at the pre-planning session. This session may occur in person or over the phone.

Service Plan Development Process

Describe the process that is used to develop the person-centered service plan, including:

(a) who develops the plan, what individuals are expected to participate in the plan development process;

> The care manager works with the participant and their chosen allies to develop the plan of service during a face to face meeting. The participant's authorized representative is also expected to participate in the plan development process.

(b) the timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

> Within seven days of program approval, the participant and chosen allies will develop the initial plan of service. If the participant is experiencing a crisis situation that requires immediate services at the time of enrollment and is not ready to fully participate in person-centered planning, an interim plan of service may be developed by the care manager and other medical staff and approved by the participant and the participant's authorized representative. Interim service plans are authorized for no more than 30 days without a follow-up visit to determine the participant's status and whether any changes need to be made to the plan.
>
> The plan of service is based on the expressed needs and desires of the participant and is updated upon request of the participant. The participant will contact his or her case manager to make a change to the plan, schedule a person centered planning meeting to update the plan, or both. Regular updates also occur when the need for services or when participant circumstances change, but at least once every six months. Regular updates may be initiated by the participant, authorized representative, or case manager.
>
> All meetings are scheduled and planned at locations, dates, and times chosen by the participant.

(c) the types of assessments that are conducted to support the service plan development process, including securing information about the individual's needs, preferences and goals, and health status;

The Mayo-Portland Adaptability Inventory (MPAI) assessment is the basis for the BIW assessment. Upon enrollment in the BIW, care managers and other medical professionals perform a comprehensive evaluation and complete the MPAI including an assessment of the individual's unique preferences, physical, social and emotional functioning, medication, physical environment, natural supports, and financial status. The case manager and medical professionals must fully engage the participant in the interview to the extent of the participant's abilities and tolerance. Once the assessment is completed, the case manager uses the information obtained to inform the participant and the person-centered planning process to assure the plan addresses the identified issues found through the assessment process.

(d) how the individual is informed of the services that are available under the Demonstration;

The participant is informed of services available by the case manager. This occurs through direct communication (either in person, electronically, or over the telephone) with the case manager as well as through written information provided to the participant regarding waiver services and other available community services and supports. The participant is offered information on all possible service providers. The participant specifies how he/she wishes to receive services and this is included in the service plan.

(e) how the plan development process ensures that the service plan addresses the individual's goals, needs (including health care needs), and preferences;

MDHHS has developed a person-centered planning practice guide. The document is available on the MDHHS website to assist case managers in ensuring that the plan of service clearly identifies the participant's needs, goals and preferences with the services specified to meet them. The case manager and participant base the service plan upon participant preferences and needs identified through the assessment and person-centered planning process. A written plan of service is developed with each participant and includes the individual's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services provided to or needed by the participant and is developed before BIW services are provided. Case managers arrange BIW services based upon participant choice, professional recommendations, and approval of the participant, participant's authorized representative, providers, and the Medicaid Agency. The participant and the case manager explore other funding options and intervention opportunities when personal goals include things beyond the scope of BIW services.

(f) how Demonstration and other services are coordinated;

> The plan of service clearly identifies the types of services needed from both paid and non-paid providers of services and supports. The amount (units), frequency, and duration of each waiver service to be provided are included in the plan. The participant chooses the services that best meet their needs and rely on the case manager to ensure the services are implemented and provided according to the plan of service. The case manager ensures that services and supports are implemented as planned. Case managers oversee the coordination of State Plan and BIW services included in the service plans. This oversight ensures that BIW services in the service plans are not duplicative of similar State Plan services available to or received by the participant.
>
> Participants enrolled in both the BIW and MI Choice waiver have the service plan coordinated by their MI Choice supports coordinator. The supports coordinator assures that MI Choice and BIW services are not duplicative and that the participant receives the BIW and MI Choice services included in the plan of service. The supports coordinator attends BIW case management meetings to assure the plan of service is updated as necessary and to assure a smooth transition out of the BIW when appropriate.

(g) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

> The assignment of responsibilities to implement the plan are determined through person-centered planning process and may be delegated to the participant, a case manager, or others designated by the participant. The case manager and the participant or participant's authorized representative are responsible for monitoring the plan. This occurs through periodic case reviews, monthly contacts, participant request, reassessments, and routine formal service provider monitoring of expenditures made on behalf of the participant.

(h) Indicate how and when the plan is updated, in addition to when the individual's needs change;

Case managers are required to contact participants at least monthly. This monthly contact may be by telephone or in person. Reassessments are conducted in person every 90 days after the initial assessment or upon a significant change in the participant's condition. Case managers conduct an in person reassessment of the participant for the purpose of identifying changes that may have occurred since the initial assessment or previous reassessment and to measure progress toward meeting specific goals outlined in the participant plan of service. The plan of service is also reviewed and updated during this process, based upon reassessment findings and participant preferences. The plan of service is also updated after changes in status and upon participant request.

(i) indicate the frequency with which the service plan is reviewed and the service delivery oversight process; and

The service plan is reviewed at least every 90 days, or sooner if indicated. Service delivery is overseen by the case manager and the Medicaid Agency. The Medicaid Agency prior authorizes all BIW services on the plan of service. The Medicaid Agency will periodically compare Medicaid claims with the prior authorized services to assure services are delivered as planned. The Medicaid Agency will also receive updates from the case manager and other medical professionals involved in the delivery of services to the participant to assure services are being delivered as planned, and meeting the participant's needs. MSA Staff may also attend case conferences as needed and when appropriate.

(j) Indicate whether the Demonstration allows for self-direction by budget, hire/fire authority or both.

The demonstration does not allow for self-direction.

Criminal History and/or Background Investigations

Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide Demonstration services:

Are criminal history and/or background investigations required?

☒Yes ☐No

If yes, indicate the types of positions for which such investigations must be conducted:

☒Administrative Staff ☒Transport Staff
☒Staff, providers and others who have direct contact with the individual

☐Others (please describe)

Indicate the scope of such investigations:

☐National (FBI) criminal records check
☒State criminal records check only
☐Other (please describe)

Abuse Registry Screening
Does the State maintain an abuse registry and requires the screening of individuals through this registry?

☐Yes ☒No

If yes, specify the entity (entities) responsible for maintaining the abuse registry:

Indicate the types of positions for which abuse registry screenings must be conducted:

☐Administrative Staff ☐Transport Staff
☐Staff, providers and others who have direct contact with the individual
☐Others (please describe)

Allowable Settings
Are Demonstration services provided in facilities subject to §1616(e) of the Act?

☒Yes ☐No

If yes, indicate the types of facilities where Demonstration services may be provided, any capacity limits for such facilities, the home and community based services that may be provided in such facilities, and how a home and community character is maintained in these settings.

Demonstration services will be allowed in Adult Foster Care Homes and Homes for the Aged. The State of Michigan licenses five types of Adult Foster Care (AFC) homes that may be used by BIW participants. Capacity limit for Family Homes are 1 - 6; Small Group Homes are 1-12; Medium Group Homes are 7-12; Large Group Homes are 13-20; and Congregate Homes are larger than 21 residents. Michigan is phasing out the licensing of Congregate Homes, but existing homes continue to operate.

Homes For The Aged (HFA)are supervised personal care facilities (other than a hotel, adult foster care facility, hospital, nursing facility, or county medical care facility) that provide room, board, and supervised personal care to unrelated, non-transient individuals 60 years of age or older. Each HFA is licensed for a specific number and cannot exceed that capacity. If an HFA is connected to a nursing facility, it can only be licensed for 20 or fewer individuals. If it is not connected to a nursing facility, an HFA can be licensed for 21 or more individuals.

All facilities will be evaluated and deemed compliant with the Home and Community Based settings ruling using one of Michigan's Home and Community Base Settings evaluation instruments before BIW services are provided in such settings.

Individuals receiving Transitional Residential (TR) Rehabilitation services often reside in a provider-owned AFC home while receiving those services. This residency would be temporary and only in place as long as the individual required the TR rehabilitation services as supported in the person-centered plan of service and chosen by the participant or participant's authorized representative. TR rehabilitation services are limited to no more than six months. Discharge planning begins upon the start of TR rehabilitation services so that appropriate community based residency is found upon meeting the goals of the TR rehabilitation services. All deviations from the home and community based settings ruling required by the nature of the brain injury to assure the health and welfare of the individual will be included in the person-centered plan of care and will comply with the rule.

Individual Rights

In addition to fair hearings, does the State operate other systems for dispute resolution, grievances or complaints concerning the operation of the Demonstration program's home and community-based services component?

☒Yes ☐No

Quality Improvement Strategies

Provide a description of the quality improvement strategies to be employed in the operation of the Demonstration. In particular describe strategies to ensure the health and welfare of individuals to be served with Home and Community-Based Services, including the prevention of abuse, neglect and exploitation (e.g., critical incident management system, utilization review, case management visits, etc.), the single State

Medicaid Agency oversight and involvement. Please also include the self-direction strategy if the Demonstration allows for self-direction.

The Medicaid Agency will use an electronic Critical Incident Management System for BIW participants. Critical incidents the Medicaid Agency requires to be reported for review and follow-up action are:

Exploitation - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Illegal activity in the home with potential to cause a serious or major negative event – Any illegal activity in the home that puts the participant or the workers coming into the home at risk.

Neglect - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law or rules, policies, guidelines, written directives, procedures, or individual plans of service that cause or contribute to non-serious physical harm or emotional harm, death, or sexual abuse of, serious physical harm to a recipient, or the intentional, knowing or reckless acts of omission or deprivation of essential needs (including medication management).

Physical abuse - The use of unreasonable force on a participant with or without apparent harm. Includes unreasonable confinement (physical or chemical restraints, seclusion, and restrictive interventions).

Provider no shows - Instances when a provider is scheduled to be at participant home but does not come and back-up service plan is either not put into effect or fails to get an individual to the participant home in a timely manner. This becomes a critical incident when the participant is bed bound or in critical need and is dependent on others.

Sexual abuse - (i) Criminal sexual conduct as defined by sections 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
(ii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
(iii) Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

"Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the

purpose of sexual arousal or ratification, done for a sexual purpose, or in a sexual manner for any of the following:
(i) Revenge.
(ii) To inflict humiliation.
(iii) Out of anger.
"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Theft - A person intentionally and fraudulently takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

Verbal abuse - Intimidation or cruel punishment that causes or is likely to cause mental anguish or emotional harm.

Worker consuming drugs or alcohol on the job – Use of any drugs or alcohol that would affect the abilities of the worker to do his or her job.

Suspicious or Unexpected Death - That which does not occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age. These incidents are often also reported to law enforcement.

Medication errors - Wrong medication, wrong dosage, double dosage, or missed dosage which resulted in death or loss of limb or function or the risk thereof.

Providers and case managers have first line responsibility for identifying, investigating, evaluating and follow-up of critical incidents that occur with participants as listed above. Providers and case managers take appropriate action upon suspicion or determination of abuse, neglect and exploitation. Appropriate action includes, but is not limited to reporting suspected abuse, neglect, or exploitation to Adult Protective Services and local authorities. Michigan Public Act 519 of 1982 (as amended) mandates that all human service providers and health care professionals make referrals to the Department of Health and Human Services Adult Protective Services (DHHS-APS) unit when the professional suspects or believes an adult is being abused, neglected, or exploited. The Vulnerable Adult Abuse Act (P.A. 149 of 1994) creates a criminal charge of adult abuse for vulnerable adults harmed by a caregiver. Providers and case managers must also report suspected financial abuse per the Financial Abuse Act (MI S.B. 378 of 1999). Providers and case managers must follow up activities with DHHS-APS to determine the result of the reported incident and next steps to be taken if the results are unsatisfactory. All reports of the suspected abuse, neglect or exploitation, as well as the referral to DHHS-APS, must be maintained in the participant's case record.

Timeframes are as follows:

Providers and case managers should begin to investigate and evaluate critical incidents with the participant within two business days of identification that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to the Medicaid Agency within two business days.

Providers and case managers are responsible for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Providers and case managers are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of the incident. The online system allows the Medicaid Agency to review the reports in real time and ask questions or address concerns with the providers and case managers.

The Medicaid Agency will use MAPI data to measure improvement in functional ability of program participants. The MAPI will be administered upon admission and at least every 90 days thereafter. Differences in functional ability between the current and previous MAPI will be analyzed and reported for participants. Individual results will be summarized in any program reports to protect health information. MAPI data will also be used to measure participant independence and community participation upon admission and at least every 90 days thereafter.

The Medicaid Agency will evaluate progress made toward goals specified on the plan of care to determine whether participants met or exceeded their goals after one year of enrollment or upon completion of the program.

The Medicaid Agency will measure annual Medicaid costs for BIW participants and compare these expenditures to the cost of beneficiaries receiving institutional care.

The Medicaid Agency will contract with the University of Michigan to conduct quality of life surveys for BIW participants and provide an analysis of the results. The quality of life surveys will be conducted upon enrollment, and every six months thereafter.

Michigan's Brain Injury Waiver
Attachment B: LTSS Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: **Brain Injury Day Treatment Program**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Services that are necessary for the treatment of the individual's brain injury. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization and to reinforce other therapeutic services received. These services consist of the following elements:

a. individual and group therapy with medical professionals;
b. occupational therapy, requiring the skills of a qualified occupational therapist;
c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with brain injuries;
d. individual and group activity therapies that are goal oriented, and
e. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment);

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Brain Injury Day Treatment Program services shall not be provided on the same day as other brain injury rehabilitation services.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount 5 hours per ☒ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Brain injury day treatment services are not provided on the same day as brain injury rehabilitation services.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

5	Day(s)	Monday, Tuesday, Wednesday, Thursday, Friday
	Week(s)	
24	Month(s)	BI Day Treatment services are limited to no more than 24 months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Services must be prior authorized by the Medicaid Agency and included in the participant's plan of care.

Provider Specifications and Qualifications

Provider Category(s):

Adult Day Care with Brain Injury specialization

☐Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be an adult day treatment center that specializes in treating individuals with brain injuries. The day treatment center must coordinate services with the individual's therapists to assure proper services and treatment while at the program.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Agency		Yes	Certified Brain Injury Specialist

Name of Benefit or Service: **Community Transition Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; and, (f) activities to assess need, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the plan of service development process, clearly identified in the plan of service and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount [ ] per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. Community Transition Services do not include monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional and recreational purposes. Community Transition Services may only be used once per BIW enrollment period.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
	Month(s)	
X	(Other)	Once per BIW enrollment. Individuals who are concurrently enrolled in the MI Choice Waiver and the BIW or MI Health Link and BIW are not eligible for Community Transition Services through the BIW.

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care.

Provider Specifications and Qualifications

Provider Category(s):

Agencies

☐Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Centers for Independent Living, retail stores

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Center for Independent Living	No	No	
Retail Stores	No	No	

Name of Benefit or Service: **Specialized Medical Equipment, Supplies, and Assistive Devices**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Specialized medical equipment, supplies, and assistive devices include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. This service includes training the participant or caregivers in the operation and maintenance of the equipment or device and the use of the supply.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount [ ] per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. Individuals who are concurrently enrolled in the MI Choice Waiver and the BIW or MI Health Link and the BIW are not eligible for specialized medical equipment, supplies and assistive devices through the BIW.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care. Specialized medical equipment, supplies and assistive devices may be obtained for individuals receiving BI Transitional Residential Rehabilitation Services.

Provider Specifications and Qualifications

Provider Category(s):

Agency

☐Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Enrolled Medicaid or Medicare DME providers, Retail Stores

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Enrolled Medicaid or Medicare DME Provider	No	No	Each direct service provider must enroll in Medicare or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.
Retail Stores	No	No	

Name of Benefit or Service: **Environmental Accessibility Adaptations**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's plan of service, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount [ ] per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Individuals who are concurrently enrolled in the MI Choice Waiver and the BIW or MI Health Link and the BIW are not eligible for environmental accessibility adaptations through the BIW.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
	Month(s)	
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of service. Environmental accessibility adaptations needed for individuals receiving BI Transitional Residential Rehabilitation Services will not be considered completed until the individual returns to their home.

Provider Specifications and Qualifications

Provider Category(s):

☒Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Retail stores, contracted providers

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Retail Store	No	No	
Licensed Contractor (business)	Yes	No	
Licensed Contractor (individual)	Yes	No	

Name of Benefit or Service: **Counseling**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation. Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral health needs.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 8 units per ☐ Day ☒ Week ☐ Month ☐ Year

☒ Other, describe:

Individuals who qualify for counseling through the State plan, the MI Choice waiver, or through the local Community Mental Health programs are not eligible to receive Counseling services through the BIW.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

		Day(s)	
		Week(s)	
24		Month(s)	BI Counseling services are limited to no more than 24 months.
		(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of services.

Provider Specifications and Qualifications

Provider Category(s):

☒Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

a. A master's degree in social work, psychology, psychiatric nursing, or counseling, or
b. A bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree.
c. Specializes in individuals with brain injuries.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Counselor	Yes	Yes	Brain injuries
Psychologist	Yes	Yes	Brain injuries
Social Worker	Yes	Yes	Brain injuries
Registered Nurse	Yes	Yes	Brain injuries
Board Certified Behavior Analyst	Yes	Yes	Brain injuries

Name of Benefit or Service: **Prevocational Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of prevocational services.

Prevocational services enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Participation in prevocational services is not a required pre-requisite for individual supported employment services provided under the waiver.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount 5 hours per ☒ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Individuals who qualify for prevocational services through Michigan Rehabilitation Services or through the local Community Mental Health program are not eligible to receive prevocational services through the BIW.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
24	Month(s)	BI Prevocational services are limited to no more than 24 months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care.

Provider Specifications and Qualifications

Provider Category(s):

Brain Injury Specialists

☒Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be accredited or certified by CARF, CORF, or AAAASF with specialization for treating brain injuries. In areas of the state where there is limited or no access to CARF, CORF, or AAAASF providers with additional accreditation or certification in Brain Injury, the Medicaid Agency may allow individual providers who are Certified Brain Injury Specialists and work in a health care program with additional licensing or accreditation to become brain injury providers.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Occupational Therapist	Yes	Yes	Brain injuries
Vocational Therapists	Yes	Yes	Brain injuries

Name of Benefit or Service: **Supported Employment**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Supported Employment Services include the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services will be provided through customized employment for individuals with significant disabilities related to their brain injury that promote community inclusion and integrated employment.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, and benefits and work-incentives planning and management. This service also includes workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount | 5 hours | per ☒ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

Individuals who qualify for supported employment services through Michigan Rehabilitation Services or through the local Community Mental Health program are not eligible to receive supported employment services through the BIW.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
24	Month(s)	BI Supported Employment services are limited to no more than 24 months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care.

Provider Specifications and Qualifications

Provider Category(s):

Brain Injury Specialists

☒Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be accredited or certified by CARF, CORF, or AAAASF with specialization for treating brain injuries. In areas of the state where there is limited or no access to CARF, CORF, or AAAASF providers with additional accreditation or certification in Brain Injury, the Medicaid Agency may allow individual providers who are Certified Brain Injury Specialists and work in a health care program with additional licensing or accreditation to become brain injury providers.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Occupational Therapist	Yes	Yes	Brain injuries
Vocational Therapist	Yes	Yes	Brain injuries

Name of Benefit or Service: **Targeted BIW Case Management**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Services that assist participants in gaining access to needed BIW and medical, social, educational and other services and supports needed as a result of the participant's brain injury, regardless of the funding source for the services to which access is gained. The BIW case manager specializes in gaining access to services related to the participant's brain injury and may need to coordinate with other case managers or supports coordinators to secure services and supports needed that are not brain injury specific and to assure services are not duplicated. Additionally, the BIW case manager will need to assure the services received concurrently through other programs reinforce and supplement BIW therapies received.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount 1 unit per ☐ Day ☐ Week ☒ Month ☐ Year

☐ Other, describe:

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
24	Month(s)	Targeted BIW case management services are limited to no more than 24 months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Case management services must be prior authorized by the Medicaid Agency and included on the individual's plan of care. Individuals concurrently enrolled in the MI Choice waiver and BIW or MI Health Link and BIW must develop a coordinated plan of services to assure services through those programs do not duplicate BIW services and to assure BIW participants receive the services and supports needed to reinforce and supplement BIW therapies received.

Provider Specifications and Qualifications

Provider Category(s):

Brain Injury Specialists

☒Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be accredited or certified by CARF, CORF, or AAAASF with specialization for treating brain injuries. In areas of the state where there is limited or no access to CARF, CORF, or AAAASF providers with additional accreditation or certification in Brain Injury, the Medicaid Agency may allow individual providers who are Certified Brain Injury Specialists and work in a health care program with additional licensing or accreditation to become brain injury providers.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Registered Nurse	Yes	Yes	Brain Injuries
Social Worker	Yes	Yes	Brain Injuries
Certified Case Manager	Yes	Yes	Brain Injuries
Licensed Counselor	Yes	Yes	Brain Injuries

Name of Benefit or Service: **Brain Injury Home and Community-Based Rehabilitation Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

This service encompasses the entire scope of therapies available to treat individuals with brain injuries in home and community-based settings through the Brain Injury Waiver. Health professionals delivering this service have received advanced training on how to provide therapy to individuals with brain injuries and the health care professional furnishing the service has modified the therapy to be more effective for these individuals. The provider will maintain records that support the actual therapies received by each participant. This service comprises the following therapies:

a. BI-Specific Physical Therapy
b. BI-Specific Occupational Therapy (includes pre-driving services)
c. BI-Specific Speech Language Pathology Therapy
d. BI-Specific Recreational, Music, Fitness, or other Therapy

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: 5 hours per ☒ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe:

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
24	Month(s)	BI HCBS Rehabilitation services are limited to no more than 24 months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care. Individuals receiving this service must start discharge planning as soon as possible.

Provider Specifications and Qualifications

Provider Category(s):

Brain Injury Specialists

☒Individual (list types) ☒Agency (list types of agencies)
The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be accredited or certified by CARF, CORF, or AAAASF with specialization for treating brain injuries. In areas of the state where there is limited or no access to CARF, CORF, or AAAASF providers with additional accreditation or certification in Brain Injury, the Medicaid Agency may allow individual providers who are Certified Brain Injury Specialists and work in a health care program with additional licensing or accreditation to become brain injury providers.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Physical Therapist	Yes	Yes	Brain Injuries
Occupational Therapist	Yes	Yes	Brain injuries
Speech Language Pathology Therapist	Yes	Yes	Brain injuries
Recreational Therapist	No	Yes	Brain injuries
Neurobehavioral Rehabilitation Therapist	Yes	Yes	Brain injuries
Dietician/Nutritional therapist	Yes	Yes	Brain injuries
Respiratory Therapist	Yes	Yes	Brain injuries
Registered Nurse	Yes	Yes	Brain injuries
Social Worker	Yes	Yes	Brain injuries
Certified Fitness Trainer	No	Yes	Brain injuries
Athletic Trainer	Yes	No	Brain injuries

Name of Benefit or Service: **Brain Injury Transitional Residential Rehabilitation Services**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

This service encompasses the entire scope of therapies available to treat individuals with brain injuries in an in-patient setting through the Brain Injury Waiver. Health professionals delivering this service have received advanced training on how to provide therapy to individuals with brain injuries and the health care professional furnishing the service has modified the therapy to be more effective for these individuals. The provider will maintain records that support the actual therapies received by each participant. This service is limited to six months. This service comprises the following therapies:

e. BI-Specific Physical Therapy
f. BI-Specific Occupational Therapy (includes pre-driving services)
g. BI-Specific Speech Language Pathology Therapy
h. BI-Specific Recreational, Music, Fitness or other Therapy
i. BI-Specific Neurobehavioral Rehabilitation Therapy
j. BI-Specific Dietician/Nutrition Therapy
k. BI-Specific Respiratory Therapy

This service will have three levels depending upon the needs of the individual.

1. Complex/high tech level of care includes individuals who have a Rancho-Los Amigos score of V-VI, are medically stable, impulsive, display inappropriate behaviors, easily frustrated, have attentional deficits, require redirection, and have inappropriate verbalizations.
2. Intermediate level of care includes individuals who have a Rancho-Los Amigos score of V-VIII, are medically stable, display mild to severe aggression, are impulsive, easily frustrated, inappropriate verbalization that require structure, cues, and redirection, impulsive verbalization, minimal confusion.
3. Minimal level of care includes individuals who have a Rancho-Los Amigos score of VI-VIII, are medically stable may have mild aggression that is easily redirected, behavior also is redirected easily, need assistance with basic care and daily living activities.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount | 5 hours | per ☒ Day ☐ Week ☐ Month ☐ Year

☐ Other, describe:

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

	Day(s)	
	Week(s)	
6	Month(s)	Transition Residential Rehabilitation is limited to no more than six months.
	(Other)	

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services must be prior authorized by the Medicaid Agency and included on the individual's plan of care. Individuals receiving this service must start discharge planning as soon as possible.

Provider Specifications and Qualifications

Provider Category(s):

Brain Injury Specialists

☐Individual (list types) ☒Agency (list types of agencies)

The service may be provided by a:
☐Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

Providers must be accredited or certified by CARF, CORF, or AAAASF with specialization for treating brain injuries. In areas of the state where there is limited or no access to CARF, CORF, or AAAASF providers with additional accreditation or certification in Brain Injury, the Medicaid Agency may allow individual providers who are Certified Brain Injury Specialists and work in a health care program with additional licensing or accreditation to become brain injury providers.

Specify the types of providers of this benefit or service and their required qualifications:

Provider Type	**License Required (Yes/No)**	**Certificate Required (Yes/No)**	**Other Qualifications Required for this Provider Type (please describe)**
Physical Therapist	Yes	Yes	Brain Injuries
Occupational Therapist	Yes	Yes	Brain injuries
Speech Language Pathology Therapist	Yes	Yes	Brain injuries
Recreational Therapist	Yes	Yes	Brain injuries
Neurobehavioral Rehabilitation Therapist	Yes	Yes	Brain injuries
Dietician/Nutritional therapist	Yes	Yes	Brain injuries
Respiratory Therapist	Yes	Yes	Brain injuries
Registered Nurse	Yes	Yes	Brain injuries
Social Worker	Yes	Yes	Brain injuries
Certified Fitness Trainer	Yes	Yes	Brain injuries

Michigan Brain Injury Waiver
Attachment C: Brain Injury Services and Rates

Service	Brief Service Description	Rate
BI Day Treatment Program	Day treatment program, per hour	$ 40.17
BI Transitional Residential Rehabilitation Services	Long-term residential therapies with complex level of care, without room and board, per diem	$ 279.60
	Long-term residential therapies with intermediate level of care, without room and board, per diem	$ 233.00
	Long-term residential therapies with minimal level of care, without room and board, per diem	$ 186.40
BI HCBS Rehabilitation Services	Services performed by a qualified physcial therapist, per hour	$ 78.12
	Services performed by a qualified occupational therapist, per hour	$ 63.39
	Services performed by a qualified speech-language pathologist, per hour	$ 78.12
	Activity therapy, per session (45 minutes or more)	$ 66.54
Case Management	Targeted case management, per month	$ 291.57
Supported Employment	Supported employment, per 15 minutes	$ 7.80
Prevocational Services	Skills training and development, per 15 minutes	$ 12.50
Counseling	Behavioral health counseling and therapy, per 15 minutes	$ 22.37
Environmental Accessibility Adaptations	Home modifications; per service	Varies
Specialized Medical Equipment, Supplies, and Assistive Devices	Exercise Equipment	Varies
	Bathtub wall rail, each	Varies
	Bathtub rail, floor base	Varies
	Toilet rail, each	Varies
	Raised toilet seat	Varies
	Tub stool or bench	Varies
	Bed accessory; board, table, or support device, any type	Varies
	Personal care item, NOS, each	Varies
	Misc. therapeutic items & supplies, retail purchases, NOC	Varies
	Specialized supply, NOS, waiver	Varies
	Specialized medical equipment, NOS, waiver	Varies
Community Transition Services	Community transition, waiver; per service	Varies

Attachment D
Budget Neutrality Form

Section 1115 Medicaid Demonstrations should be budget neutral. This means the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration. In this section, the state must provide its explanation of how the Demonstration program will achieve budget neutrality and the data to support its rationale.

New Demonstration Request: The following form provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS is available to provide technical assistance to individual states to identify any other elements needed to demonstrate budget neutrality for their specific request. Use the accompanying Excel Workbook to submit supporting data, following the instructions below. All expenditure totals in the Excel Workbook are total computable expenditures (both federal and state shares combined), unless indicated otherwise.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.

The “Historical Data” tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers “HY 1,” “HY 2,” etc., should be replaced with the actual historical years.

The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.

States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the “Historical Data” tab to provide 5 years of historical data for the new populations.

Population/Sub-Population Name:	Brain Injury Beneficiaries in Nursing Homes and Hospitals
Brief Description	Expenditures are based on a blend of average costs for nursing homes, NH vent, and hospitals.
Relationship to Section II	Mandatory, Optional and Medically Needy groups

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	
Brief Description	
Relationship to Section II	

Explain the sources and methodology used for the actual and/or estimated historical data. If actual data have been provided, explain the source of the data (MMIS data, other state system Medicaid data, other program data, etc.) and the program(s) and source(s) of program funding that the data represent. Indicate if the data represent all Medicaid expenditures for the population. For example, are they inclusive of long-term care expenditures? Were the expenditures reported on the CMS-64? If the data provided are a combination of actual and estimated data, provide the dates pertaining to each type of data. If any of the data are estimated, provide a detailed explanation concerning how the estimated data were developed.

The historical cost is estimated utilizing MMIS data. Since the Brain Injury Waiver was not in place in the past, we determined that those beneficiaries would have obtained the majority of their needed care in a nursing home, with or without need for a ventilator, or in a hospital. The estimates for the facilities are based on a blend of average costs during those periods for nursing homes, nursing homes with ventilator units, and hospital stays, as it was assumed that beneficiaries would have obtained the majority of their needed care in those settings. The mix of facility type for this estimate is based on historical information regarding the proportion of beneficiaries being serviced in those types of facilities during this historical period: Nursing Homes – 70%, Nursing Homes with Ventilator Units – 10%, and Hospitals – 20%. The rates used for each of those types of facilities are based on the average daily costs during each of the historical periods. The cost estimates were calculated for 12 months of the year for 100 individuals, which is the maximum number of beneficiaries that would be allowed to participate in the Brain Injury Waiver program each year.

B. Bridge Period

Based on the ending date of the most recent year of historic data and the proposed Demonstration implementation date, a bridge period will apply to this proposal. Estimates of Demonstration costs must be trended across this bridge period when calculating the projected first year of

PMPM costs without the waiver.

In the blanks below, enter the last day of the most recent historical year, and the last day of the year immediately preceding the first Demonstration Year. The number of months between these dates is the length of the bridge period. Depending on the length of the available historical data series and data quality, each demonstration population could have its own unique bridge period.

Enter the number of months in the bridge period in the "WOW" tab of the Excel Workbook, in the grayed cell under "MONTHS OF AGING." The spreadsheet is programmed to project Demonstration Year PMPM expenditures and member month totals using historical trend rates and the length of bridge period, and assumes that the same bridge period applies to all calculations. Applicants should feel free to alter these programming features as needed.

Demonstration Bridge Period: 10/01/2015 to 01/01/2017

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to "Pop Type," the correct option should be selected to identify each group as a Medicaid population.

The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state's historical trends and President's Budget trends to determine the WOW baseline.

Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common "jumping off point" for both WOW and with waiver (WW) projections.

D. Risk

CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:

PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.

AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The "WW" tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce

PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.

This trend rate for the With-Waiver estimate is determined from the recommended Diversionary Model Budget Neutrality Workbook provided by CMS. It is the 5 year average of annual change calculated from the historic data. That 5 year average was used as the trend rate to project the PMPM costs for each of the future 5 years of this Brain Injury Waiver program that is planned to begin on January 1, 2017. It was estimated that this waiver will not be fully enrolled during the first 5 years of the demonstration period. However, partial enrollment in the waiver program will mean fewer beneficiaries would remain in nursing facilities, thus diverting those costs to the waiver program that has lower PMPM costs.

II. Cost Projections for New Populations

This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration.

In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.

Population Name		Brief Description	Cross-Walk to Section II
BIW Participants		MA eligible individuals with qualifying brain injury	Mandatory, Optional, Medically Needy

Justification for New Populations' Trend Rate, PMPM and Member Month Projections

The state must provide below a justification for the proposed trend rate, estimates of PMPM costs, and number of member months for new populations, including a description of the data sources and estimation methodology used to produce the estimates. Historical data provided to support projections for new populations can be displayed in the Excel Workbook's Historic Data tab.

Refer to Attachment D Section F.II. Cost Projections for New Populations

Some state proposals may include populations that could be made eligible through a State plan

amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.

III. Disproportionate Share Hospital Expenditure Offset

Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?

☐ Yes ☑ No

If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state's historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.

In the DSH tab of the Excel Workbook, enter the state's DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.

Provide an explanation for any Adjusted DSH Claim Amounts:

In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.

The Excel Workbook is set up to allow for the possibility that Demonstration Years will not coincide with federal fiscal years. If this is the case, and the Demonstration is proposed to last for five full years, then the Demonstration will be in existence for parts of six federal fiscal years. FFY 00 is the federal fiscal year during which the Demonstration is proposed to begin, and FFY 05 is the federal fiscal year that contains the Demonstration's proposed end date. CMS encourages states that use DSH diversion in their budget neutrality model to define Demonstration Years so that they align with the Federal fiscal years. (If Demonstration Years do align with Federal fiscal years, it is not necessary to populate the column for FFY 00.)

In Panel 3 of the Excel Workbook, the rows are set up to be used as follows. All amounts entered in Panel 3 are Federal share.

- State DSH Allotment: Formulas in the Excel Workbook automatically enter the same DSH allotment projects as are shown in Panel 2.
- State DSH Claim Amount: Enter the amounts that the state projects will be spent on DSH payments to hospitals for each federal fiscal year that overlaps with the proposed demonstration period.
- Maximum DSH Allotment Available for Diversion: If the state wishes to propose a dollar limit on the amount of potential DSH spending that is diverted each year, enter those amounts here. If no such limit is proposed, leave blank.
- Total DSH Allotment Diverted: The Excel Workbook is structured to populate the cells in this row from amounts entered in Panel 4. CMS's default assumption is that DSH diversion spending will align with the Federal fiscal year DSH allotments based on date of service. The Excel Workbook allocates DSH diversion spending from one or two overlapping Demonstration Years to each Federal fiscal year DSH allotment.
- DSH Allotment Available for DSH Diversion Less Amount Diverted: This row provides a check to ensure that diverted DSH spending does not exceed the Maximum DSH Allotment amount specified by the State. If no Maximum DSH Allotment, delete the formulas in this row.

- DSH Allotment Projected to be Unused: This row provides a check to ensure that the combination of diverted DSH spending plus DSH payments to hospitals does not exceed the DSH allotment each year.

Panel 4 of the Excel Workbook provides space for the state to indicate amounts of DSH diversion spending are planned for each Demonstration Year, and specify how much of that amount is to be assigned to the overlapping Federal fiscal years. DSH diversion spending is entered here as a total computable expenditures. An FMAP rate is needed for each total computable spending amount entered to enable it to be converted into a federal share equivalent that will appear in Panel 3. The amounts shown in the Total Demo Spending From Diverted DSH row automatically appear in the Summary tab in the Without Waiver panel.

Explanation of Estimates, Methodology and Data

IV. Summary of Budget Neutrality

The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be non-negative.

As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.

V. Additional Information to Demonstrate Budget Neutrality

Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.

The report for this Budget Neutrality submission uses the Diversionary Model Budget Neutrality Workbook rather than the standard 1115 Demonstration Budget Neutrality Workbook, as recommended by CMS. In addition, we anticipate the Brain Injury Waiver will provide better health outcomes, and overall cost will be less for persons with brain injuries living in the community versus staying in nursing homes and hospitals.

Section F. II. Cost Projections for New Populations

Brain Injury Day Treatment Program
Enrollees require supervision and monitoring. Reinforce skills learned during rehabilitation program. At adult day care.

25 individuals would utilize this service for 4 hours per day, 2.5 days per week for 20 weeks.

Brain Injury Rehabilitation Services
Individuals needing behavioral health care in a residential treatment program with varying degrees of level of care – Complex/High Tech, Intermediate, and Minimal. Each person would have different needs for the rehabilitation services.

Estimate that 15 people would need the complex/high tech services for 40 days, then the intermediate services for 40 days, then 20 days for the minimal services.
Estimate that 35 people would begin with intermediate services for 40 days, then 20 days for the minimal services
Estimate that 30 people would only need the minimal services for approximately 20 days
No services needed by 20 individuals

Brain Injury Rehabilitation Services
Rehabilitation services in HCBS – combination of needed physical therapy, occupational therapy, speech-language therapy, and activity therapy.

Estimate that 40 individuals would need these various therapies provided 3 days each week for 1 hour sessions over a period of 8 weeks.

Case Management
Utilized by each of the 100 individuals.

Supported Employment
25 Individuals for 3 months, 12 days per month

Pre-Vocational Services
25 individuals for 4 months, 12 days per month

Counseling
40 individuals for 3 months, 8 days per month

Environmental Accessibility Adaptations
Home modifications needed

Estimated 10 individuals would need these type of modifications with average cost of $2,000.

Attachment D Section F. II. Cost Projections for New Populations

Specialized Medical Equipment, Supplies, and Assistive Devices
Estimated 60 individuals would utilize this service with average cost of $150

NURSING HOME ESTIMATE

Estimate for Member Months for the five future years
2017 – 500
2018 – 600
2019 – 675
2020 – 725
2021 – 750

Also assumed the portion of individuals at various institutions:
70% - Nursing Facility
10% - Nursing Facility (With Ventilator unit)
20% - Hospital

Attachment E
Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

☐ State General Funds

☐ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Provider taxes. (Provide description the narrative section – Section VI of the application).

☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☐ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☐ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☐ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☐ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ☐ No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ☐ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**Brain Injured Individuals in NH/NH-W/H (Est'd)**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 11,703,600	$ 12,164,400	$ 12,369,600	$ 12,434,400	$ 12,736,800	$ 61,408,800
7	**ELIGIBLE MEMBER MONTHS**	1,200	1,200	1,200	1,200	1,200	
8	**PMPM COST**	$ 9,753.00	$ 10,137.00	$ 10,308.00	$ 10,362.00	$ 10,614.00	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		3.94%	1.69%	0.52%	2.43%	2.14%
12	ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	0.00%	0.00%
13	PMPM COST		3.94%	1.69%	0.52%	2.43%	2.14%
14							
15							
16							
17							
18							
19	Brain Injury (Est'd) 1. Member months are based on approximations of number of individuals that historically may have been eligible for the new Brain Injury Waiver program. 2. Expenditures are based on a blend of average costs for Nursing Homes, Nursing Homes with Ventilator units, and Hospital stays. Prior to the Brain Injury Waiver program, it is assumed that the majority of care received by these beneficiaries would occur in these settings.						

	A	B	C	D	E	F	G	H	I	J	K	L
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**											
2												
3												
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**	
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**	
6												
7	**Beneficiaries with Brain Injury in NH/NH-Vent/Hosp**											
8	**Pop Type:**	**Medicaid**										
9	Eligible Member Months	0.0%		1,200	0.0%	1,200	1,200	1,200	1,200	1,200		
10	PMPM Cost	2.1%	12	$10,841.14	2.1%	$11,073.14	$11,310.11	$11,552.15	$11,799.37	$12,051.88		
11	Total Expenditure					$ 13,287,768	$ 13,572,132	$ 13,862,580	$ 14,159,244	$ 14,462,256	$ 69,343,980	
12												
13												
14												

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Brain Injury Population Not Enrolled in Waiver								
Pop Type: Medicaid								
Eligible Member Months	1,200	0.0%	700	600	525	475	450	
PMPM Cost	$ 10,841.14	2.1%	$ 11,073.14	$ 11,310.11	$ 11,552.15	$ 11,799.37	$ 12,051.88	
Total Expenditure			$ 7,751,198	$ 6,786,066	$ 6,064,879	$ 5,604,701	$ 5,423,346	$ 31,630,190
Brain Injury Population Enrolled in Waiver								
Pop Type: Expansion								
Eligible Member Months			500	600	675	725	750	
PMPM Cost		2.1%	$ 4,190.37	$ 4,280.04	$ 4,371.63	$ 4,465.18	$ 4,560.73	
Total Expenditure			$ 2,095,185	$ 2,568,024	$ 2,950,850	$ 3,237,256	$ 3,420,548	$ 14,271,862

With the proposed 1115 Demonstration waiver, individuals served through the Brain Injury Waiver are assumed to be diverted from obtaining Medicaid services at a nursing facility or hospital. While we are targeting this waiver program for 100 beneficiaries during each year, we anticipate not having full enrollment in the initial periods. We anticipate increased enrollment each year reducing the number of persons with brain injuries in nursing facilities or hospitals.

The proposed 1115 Demonstration waiver seeks to provide a coverage benefit to individuals with certain brain injuries so they can obtain rehabilitation services while residing within the community. We estimated that the number of ellgible participants would increase each year before reaching the 100 maximum number. Since we estimated the historic cost being 100 individuals in nursing facilities & hospitals, once this waiver is in place, those participating in the brain injury waiver would not be in nursing facilities. Thus higher costs that would have been for services in nursing facilities would be diverted to those that can be done in the community at a lower cost.

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Beneficiaries with Brain Injury in NH/NH-Vent/Ho	$ 13,287,768	$ 13,572,132	$ 13,862,580	$ 14,159,244	$ 14,462,256	$ 69,343,980
TOTAL	$ 13,287,768	$ 13,572,132	$ 13,862,580	$ 14,159,244	$ 14,462,256	$ 69,343,980

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Brain Injury Population Not Enrolled in Waiver	$ 7,751,198	$ 6,786,066	$ 6,064,879	$ 5,604,701	$ 5,423,346	$ 31,630,190
Expansion Populations						
Brain Injury Population Enrolled in Waiver	$ 2,095,185	$ 2,568,024	$ 2,950,850	$ 3,237,256	$ 3,420,548	$ 14,271,862
TOTAL	$ 9,846,383	$ 9,354,090	$ 9,015,729	$ 8,841,956	$ 8,843,894	$ 45,902,052
VARIANCE	$ 3,441,385	$ 4,218,042	$ 4,846,851	$ 5,317,288	$ 5,618,363	$ 23,441,928

Population Status Drop-Down
Medicaid
Hypothetical
Expansion