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| **\*Must be filled out by agency** |
| **\*Agency/Program/Service** |       | **\*Population(s)** |  [x]  SUD |
| **\*Requestor** *Contact Name**Contact phone/email* |       | **Other Agencies Impacted** |       |
| **\*Submission Date** |       | **New or Review existing** | [ ]  New Rate [ ]  Existing Rate |

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| **Change Request Detail -** *Provide the business reasons and justification for the change and assess the risk* |
| **\*Type of Change** | **Description of the change requested with rationale** |
| [ ]  | Change in Available Resources |       |
| [ ]  | Clinical Need |
| [ ]  | Scope Change |
| [ ]  | Regulatory Requirement |
| [ ]  | Change in Payment Structure |
| **\*Provider assumptions for consideration during rate development** EXAMPLES include:* Average billable time per contact and indirect time per contact
* Clinical Staff to individual ratio
* Professional levels of clinical staff
* Wages paid to staff in program
* Ramp up assumptions, if new
* 1/12th or cost settlement – plan for transition to fee for service
* EBP fidelity to model costs
* Facility-based or in-community services, average travel assumptions
 |       |
| **\*Requested Completion Date-**if outside of policy timeline  | Explain:      |
| **\*Reportable Service Code(s)** |       |
| **\* Provider Calculations for New Service Rate(s) Request:** Please attach most recent annual fiscal year expenditures for the program(s) impacted by this request along with the total units of service provided. |

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| **LRE Internal use only** |
| **Funding Source(s)** *(check all)* | [ ]  Medicaid(b)/(b3) [ ]  Healthy Michigan [ ]  General Fund [ ]  Local [ ]  Earned Contract [ ]  Grant[ ]  SDA [ ]  PA2/Liquor Tax [ ]  Waiver/Other \_\_\_\_\_\_\_\_\_\_\_ |
| **Cross Population Collaboration**  | [ ]  None [ ]  SUD [ ]  MIExplain: |
| **Financial Impact**  | Estimated cost of the change - $       |
| **Financial Impact Plan** | Please explain how it will be funded?      |
| **LRE Assumptions**  | What does LRE want to buy?      |
| **Provider assumptions requested and considered, but not included in rate** *– include reason* |       |
| **Proposed Rate calculated by Finance Team** |       |
| **Rate Comparison**  |

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|  | PY State Avg. | PY LRP Avg. | LRE Allowables | Program Name/License Number |
| SUD |       |       |       |       |
|       |       |       |       |       |
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| **Do Business Rules Change?** | [ ]  No [ ]  Yes Describe:      If yes, approved by: [ ]  CIO [ ]  COO? [ ]  CFO  [ ]  Provider Network Coord [ ]  Dir of Policy, Plan., Comm |
| **Retro Approval?** | [ ]  No [ ]  Yes  | **Rationale if retro** |       |

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| **Status** | *.* |
| **Change Request Process Status**  |       |
| **Change Request Process Status***(per process outlined in policy)* | **Review/Approval** | **Request Status** | **Date** |
| 1. Provider Network Team  |       |       |
| 2. SARG Workgroup |       |       |
| 3. Finance ROAT |       |       |
| 4. SUD ROAT |       |       |
| 5. Executive Director Review |       |       |

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| **Contract Manager** | Contract change      Service Spec change      Agency Notification        | Date:      Date:      Date:       |
| **Disposition** | [ ]  Approved [ ]  Not Approved [ ]  Deferred |
| **Rate** |       |