DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled and Elderly Health Programs Group

DEC 17 2014

Stephen Fitton, Director
Medical Services Administration
State of Michigan, Department of Community Health
Capital Commons
400 South Pine
Lansing, MI 48909

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated December 16, 2014, for a one year extension of Michigan's Specialty Services and Supports (MSS&S) 1915(b) Waiver (MI.14). The current waiver authority expires on December 31, 2014. The waiver extension is being requested in order to address cost effectiveness issues within the waiver.

We are granting your request for a one year extension of this waiver authority to extend through December 31, 2015. We look forward to continuing the communication towards resolution. As part of this extension, CMS requires a submission of the state's waiver renewal, to include amended cost effectiveness, by October 1, 2015. CMS staff from the Chicago Regional Office, as well as, the Central Office will continue to offer technical assistance as you complete work on these issues.

If you have any questions, please contact Eowyn Ford, in the Chicago Regional Office, at (312) 886-1684, or Scott Manning, of my staff, at (410) 786-6881.

Sincerely,

Barbara Coulter Edwards

Barbara Coulter Edwards
Director

cc: Jacqueline Coleman, MDCH
Eowyn Ford, CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled and Elderly Health Programs Group

SEP 15 2014

Stephen Fitton, Director
Medical Services Administration
State of Michigan, Department of Community Health
Capitol Commons
400 South Pine
Lansing, MI 48909

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated September 5, 2014, for a three (3) month extension of Michigan's Specialty Services and Supports (MSS&S) 1915(b) Waiver (MI.14). The current waiver authority expires September 30, 2014. The waiver extension is being requested in order to address cost effectiveness issues within the waiver.

We are aware that you have been working to resolve cost effectiveness reporting issues identified in the last waiver renewal and appreciate your continued efforts to address these issues. We look forward to continuing the communication towards resolution, including the implementation of a Section 1915(i) State Plan amendment to operate concurrently with the MSS&S and Section 1915(c) waivers. CMS staff from the Chicago Regional Office, as well as, the Central Office continue to offer technical assistance as you complete work on these issues.

We are granting your request for a three (3) month extension of this waiver authority to extend through December 31, 2014. Please continue to keep us informed of your progress and contact us at any time for guidance.

If you have any questions, please contact Eowyn Ford, in the Chicago Regional Office, at (312) 886-1684 or Scott Manning, of my staff, at (410) 786-6881.

Sincerely,

Suzanne K. Bostick for

Barbara Coulter Edwards
Director

cc: Jacqueline Coleman, MDCH
Eowyn Ford, CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled and Elderly Health Programs Group

DEC 17 2013

Stephen Fitton, Director
Medical Services Administration
State of Michigan, Department of Community Health
Capitol Commons
400 South Pine
Lansing, MI 48909

Dear Mr. Fitton:

Thank you for your request, dated November 25, 2013, for a six (6) month waiver extension of Michigan's Specialty Services and Supports (MSS&S) 1915(b) waiver (MI.14). The current waiver authority expires March 30, 2014. The waiver extension is being requested in order to align Michigan's Medicare/Medicaid Demonstration project with the effective date of the waiver.

We are aware that you have been working to resolve cost effectiveness reporting issues identified in the last waiver renewal and appreciate your continued efforts to address these issues. We look forward to continuing the communication towards resolution, including the implementation of a Section 1915(i) State Plan amendment to operate concurrently with the MSS&S and Section 1915(c) waivers. Staff from the Centers for Medicare & Medicaid Services (CMS) will continue to offer technical assistance as you complete work on these issues.

We are granting your request for a six (6) month extension of this waiver authority to extend through September 30, 2014. Please continue to keep us informed of your progress and contact us at any time for guidance.

If you have any questions, please contact Maria Chickering in the Chicago Regional Office at (312) 886-0326 or Alexis Gibson in the Central Office at (410) 786-2813.

Sincerely,

Barbara Coulter Edwards

Barbara Coulter Edwards
Director

cc: Jacqueline Coleman, MDCH
Maria Chickering, CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services
Disabled and Elderly Health Programs Group

SEP 27 2013

Stephen Fitton, Director
Medical Services Administration
State of Michigan, Department of Community Health
Capitol Commons
400 South Pine
Lansing, MI 48909

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated September 5, 2013, for a ninety (90) day waiver extension of Michigan's 1915(b) Specialty Services and Supports Waiver (MI.14). The current waiver authority expires December 31, 2013. The waiver extension is being requested in order to implement a Section 1915(i) state plan amendment which will move 1915(b)(3) and 1915(c) services for people with developmental and intellectual disabilities into the 1915(i) authority.

The CMS is granting a ninety (90) day extension of this waiver authority to extend through March 31, 2014. Please continue to keep us informed of your progress and contact us at any time for guidance.

If you have any questions, please contact Eowyn Ford in the Chicago Regional Office at (312) 886-1684 or Debbie Dombrowski in the Central Office at (312) 353-1403.

Sincerely,

Suzanne Bostick for

Barbara Coulter Edwards
Director

cc: Jacqueline Coleman, MDCH
Eowyn Ford, CMS

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

March 26, 2013

Stephen Fitton, Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
Lansing, MI 48933

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) approves Michigan's amended 1915(b) waiver application for Specialty Services & Supports. The CMS has assigned this waiver amendment control number MI-14.R06.M02. The effective dates of the amended waiver are April 1, 2013 to December 31, 2013.

The waiver amendment adds to the 1915(b) waiver a new benefit under 1915(i) authority for Applied Behavioral Analysis. This benefit will serve Medicaid beneficiaries ages 18 months through 5 years who are diagnosed with Autism Spectrum Disorder.

The CMS has based this decision on evidence the state submitted that demonstrates the information contained in the amended 1915(b) waiver application is consistent with the purposes of the Medicaid program, as well as other assurances that the state will meet all applicable statutory and regulatory requirements in the operation of this 1915(b) waiver program.

If you have any questions, please contact Eowyn Ford at 312.886.1684 or Eowyn.Ford@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Jacqueline Coleman, MDCH
Debbie Dombrowski, CMCS

Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Michigan** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
MSS&S Program	Managed Specialty Services and Supports Program	PIHP;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Section 1915(b) Waiver - Michigan's Specialty Services and Supports Program

C. Type of Request. This is an:

☑ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):
Michigan is adding a new benefit under the §1915(i) authority for Applied Behavior Analysis (ABA). This benefit will serve Medicaid beneficiaries ages 18 months through 5 years who are diagnosed with Autism Spectrum Disorder (ASD).

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ◉ **2 years** ○ **3 years** ○ **4 years** ○ **5 years**

Draft ID:MI.17.06.03
Waiver Number:MI.0014.R06.02

D. Effective Dates: This amendment is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Approved Effective Date of Base Waiver being Amended: 10/01/11
Proposed Effective Date: *(mm/dd/yy)*
04/01/13
Approved Effective Date: 04/01/13

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Jacqueline Coleman **Phone:** (517) 241-7172 **Ext:** ☐ **TTY** **Fax:** (517) 241-5112 **E-mail:** colemanj@michigan.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Managed Specialty Services and Supports Program**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
On June 12, 2012, the Michigan Department of Community Health (MDCH) sent notification to Federally recognized Tribal Chairs and Health Directors of its intent to submit a §1915(i) State Plan amendment and §1915(b) amendment to the Managed Specialty Services and Supports Waiver for Applied Behavioral Analysis Therapy to CMS. The letter invited written comments and offered an opportunity to discuss the notice of intent to via phone. This notification was also posted on the MDCH website. No comments on the notification were received.

The Michigan's Department of Community Health's (MDCH)Tribal Health Liaison participates in quarterly meetings with Tribal Health Directors. These meetings serve as an ongoing forum for the identification and discussion of issues involving the State's Medicaid program. The Tribal Health Liaison shares issues involving the MSS&S program and works with staff in the Behavioral Health and Developmental Disabilities Administration (BHDDA)to resolve issues, clarify information and implement recommendations as needed.

On August 22, 2012, MDCH held a stakeholder's meeting to discuss the ABA benefit.

A public notice was sent to the major newspapers on September 20, 2012. No comments on the public notice were received. MDCH also communicated with all PIHP/CMHSP directors, at a regular quarterly meeting,on the intent to submit an amendment to include the ABA benefit.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
First Waiver Period
MDCH first received approval for a Medicaid Freedom of Choice Waiver on 06/26/98. The waiver was authorized under the §§1915(b)(1)& 1915(b)(4) of the SSA. It permitted the State to implement a program for Managed Specialty Community Mental Health Services & Supports through Michigan's public, county-based Community Mental Health Services Programs(CMHSPs). The approval also permitted Michigan to use 1915(a)(1)(A)capitation payments to provide more flexible alternative services on an individual basis in lieu of State Plan coverages. On 10/01/98 CMHSPs became Specialty Prepaid Health Plans and received capitated payments to provide services to Medicaid beneficiaries who were eligible for specialty services & supports.

CMHSPs continued to provide the services & supports that were previously provided under the Medicaid State Plan coverages. Medicaid health care services (e.g., physician services, hospital services and etc.) are not included in the CMHSP service program, and are provided by a Medicaid-enrolled health care provider.

The §1915(b) waiver operates in conjunction with Michigan's existing 1915(c)Habilitation Supports Waiver (HSW) for people with developmental disabilities. Children with developmental disabilities who live with their birth or adoptive families are enrolled in the Children's Waiver Program(CWP) and are exempt from the MSS&S Program.

Second Waiver Period
MDCH completed a procurement process to establish Prepaid Inpatient Health Plans(PIHPs). Applications submitted by CMHSPs had to demonstrate they were able to meet or had a viable plan to meet the standards. CMHSPs with geographic service areas serving less than 20,000 Medicaid beneficiaries formed affiliations to become a PIHP. Eighteen CMHSPs were selected as PIHPs for Medicaid specialty services & supports on 10/01/02.

Third Waiver Period
CMS' approval for 10/01/03 through 09/30/05 period required significant changes to services and the capitation payment process. Capitation payments for the 1915(c)HSW were made separately from the 1915(b) waiver capitation payments, and exclusively for 1915(c)enrolled beneficiaries who received a 1915(c)waiver service within the payment month. Under this renewal period CMS directed the State to use the authority of 1915(b)(3) to offer services previously authorized by §1915(a)(1)(A). PIHP payments under the §1915(b)waiver for mental health/developmental disabilities services & substance abuse services were split between an amount for State Plan services and an amount for (b)(3)services.

Fourth Waiver Period
Practice improvement was a significant area of focus. MDCH convened a state-level Improving Practices Steering Committee to lead this effort. All 18 PIHPs convened Improving Practices Leadership Teams, to oversee implementation of Evidence-Based, Promising, & Emerging Practices and began implementing at least one adult evidence-based practice (EBP). Eleven PIHPs began implementing the Parent Management Training, Oregon model children's EBP.

MDCH initiated efforts to promote a system of care based on recovery for adults with mental illness. The State convened a Recovery Council made up of primary consumer representatives. The council provides advice on policy and program development for the public mental health system. Nearly 150 peer support specialists participated in a training certification program and assisted people with mental illness in their recovery journeys.

MDCH established the Developmental Disabilities Practice Improvement Team to address concerns about the lack of opportunities for competitive jobs, relationships and independent living for people with developmental disabilities. Representatives were recruited from CMHSPs, universities, providers and advocacy organizations. The team identified desired outcomes for people with developmental disabilities, and associated opportunities and challenges.

A Fingertip Report was developed during this waiver period. PIHP performance information is published in summary tables that include: expenditures, service utilization, MDCH site review scores, external quality review scores, adverse events, encounter data, HSW and ICF/MR utilization, reporting timeliness, and Medicaid performance indicators.

Fifth Waiver Period
August 2008, MDCH issued a concept paper that addressed improving the culture of systems of care, assuring active engagement, supporting maximum consumer choice & control, expanding opportunity for integrated employment, treatment for people in the criminal justice system, assessing needs & managing care, improving the quality of supports & services, developing & maintaining a competent workforce, and achieving administrative efficiencies. The paper was followed by an "Application for Renewal and Recommitment"(ARR)that built on the 2002 Application for Participation. The ARR used a quality improvement model approach for the process of delivering supports and services, the environment in which they are delivered, and their outcomes for Medicaid beneficiaries. Nine MDCH teams reviewed the responses and provided feedback to the PIHPs. These teams will follow each PIHP over the next several years as they implement their plans for improvement and provide technical assistance and consultation.

Two other initiatives sought to improve how providers respond to people who have reputations of challenging behaviors. The first initiative was a new technical requirement for Behavior Treatment Plan Review Committees(BPTRC)that was attached to the PIHP and CMHSP contracts. This requirement identified prohibited types of interventions as well as those requiring BPTRC review and approval. The document outlined new data collection,analyses and reporting requirements,and mandated the frequency of Committee review. The Creating a Culture of Gentleness, the second initiative sought to help providers understand that there are preferred alternative ways to work with people. MDCH sponsored orientation to culture of gentleness sessions. Those were followed by regional, more intensive trainings for direct care workers, their supervisors, and case managers. MDCH established a safety net plan to respond to CMHSPs who had exhausted their capacity to respond appropriately to people who exhibit behaviors that threaten their welfare or that of others. The plan builds on the intensive trainings by adding a mobile crisis response, and a temporary crisis placement.

MDCH continued to emphasize the importance of adopting evidence-based, promising and best practices. Several PIHPs were pilot sites for a foundation-funded medication algorithm project. Mental Health Block Grant funds were used to begin pilot projects on developing methodologies for integrating mental health & physical health care. MDCH continued efforts to support a system of care based in recovery for adults with mental illness so that each person who receives public mental health services is supported in his/her individual journey of recovery. Key components included training, certification and utilization of Certified Peer Support Specialists and the work of the Michigan Recovery Council and the Recovery Center of Excellence.

Sixth Waiver Period
A new initiative in the area of self-determination was begun. MDCH uses the term self-determination,rather than the term self-direction,to emphasize the value that people use such arrangements to develop and plan a life with activities & supports that are meaningful and appropriate for them. MDCH developed a Self-Determination Policy and Practice Guideline and incorporated it into the PIHP contracts during the third waiver period. However, the implementation of service and support arrangements that support self-determination has been uneven throughout the State. Self-Determination arrangements must be offered to beneficiaries, but they may choose not to use them. Some beneficiaries indicate disinterest in using the arrangements that require a significant amount of responsibility. In addition, the PIHPs have struggled with how to apply self-determination arrangements for people who do not receive support services, but rather mental health therapies and interventions like medication review. The State sponsors bi-monthly self-determination leadership seminars for PIHP staff, has a consultant available for technical assistance, has recently revised the self-determination policy and developed a fiscal intermediary policy, both of which are attached to the MDCH/PIHP contract; and has developed guidance for providers and beneficiaries for distribution and posting on the MDCH website.

Seventh Waiver Period
MDCH partners with the Michigan Department of Human Services(DHS)to offered a statewide incentive payment to PIHPs

to increase the access and intensity of mental health services and supports provided by PIHPs to children in foster care and categories 1 and 2 Child Protective Services children/families effective 07/01/12.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   - **a.** ☑ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **MSS&S Program**
   - **b.** ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **MSS&S Program**
   - **c.** ☑ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **MSS&S Program**
   - **d.** ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **MSS&S Program**

     The 1915(b)(4) waiver applies to the following programs
     - ☐ **MCO**
     - ☑ **PIHP**
     - ☐ **PAHP**
     - ☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
     - ☐ **FFS** Selective Contracting program

     Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- Specify Program Instance(s) applicable to this statute
☐ **MSS&S Program**

b. ☑ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
-- Specify Program Instance(s) applicable to this statute
☑ **MSS&S Program**

c. ☑ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
-- Specify Program Instance(s) applicable to this statute
☑ **MSS&S Program**

d. ☑ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

-- Specify Program Instance(s) applicable to this statute
☑ **MSS&S Program**

e. ☑ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
This Waiver will operate in conjunction with Michigan's Home and Community Based Habilitation Supports Waiver, Control #MI.0167.R04.00, which is also operated by the PIHPs. That waiver is in year 3 of its 5 year renewal cycle.

State requests a waiver of §1932(a)(3) which requires that a State permit an individual to choose a managed care entity from not less than two such entities. Michigan assigns beneficiaries to a PIHP based on geography and beneficiary choice is exercised on providers and not on plans.
-- Specify Program Instance(s) applicable to this statute
☑ **MSS&S Program**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. **Delivery Systems.** The State will be using the following systems to deliver services:

a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in

that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☑ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ◉ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☑ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☑ **Other:** (Please provide a brief narrative description of the model.)

This amendment adds 1 service, Applied Behavioral Analysis (ABA), under the authority of §1915 (i) as a State Plan benefit. The ABA service will be paid differently from the §1915(b) capitation payments for a period of time until cost data is available to move this service to a risked based payment and establish actuarially sound rates. Payments for ABA services are considered non-risk at this time. It is the intent of the State to convert the payment structure to one that is risked-based as soon as it is feasible. It will be necessary to acquire a sufficient amount of cost history to move this service to a risked based payment, because this is a new service with no historical cost or utilization data upon which to base rates. The payments for this new service are broken into several parts. First, a small amount will be paid to the PIHPs in the form of gross adjustments. This will be considered a services support administrative cost. This is the only amount that will be paid prospectively. Secondly, a monthly interim payment will be sent to the PIHPs in the fifth month after a particular service month. For example, an interim payment for April 2013 would be paid in September 2013. Each interim payment will be issued at one of two levels, EIBI or ABI, and will be triggered by the combination of meeting the criteria for this benefit at a particular level, as laid out in the Autism Benefit Medicaid Policy Draft and the §1915 (i) SPA and having at least one encounter submitted by the end of the fourth month after a particular service month for that month. For example, an interim payment for April 2013 will be triggered and paid in September 2013, if a client meets all the criteria and we have received at least one encounter for ABA services by the end of August 2013. Third, there will be a cost settlement process that will cover the actual costs associated with ABA services, as well as assessments related to potential eligibility for these services, submitted for a particular fiscal year. This process could result in additional payment to or recoupment from each PIHP. That will take place no earlier than the March after the fiscal year

being settled.

If the PIHP has submitted an encounter for ABA service, it will be cost settled following the end of the fiscal year after the final cost report is submitted. The costs of ABA services, as well as assessments related to potential eligibility for these services, will be included in the cost settlement process.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☑ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ◉ **Other** (please describe)

  The State has been operating this Waiver under the procurement plan approved by the Center for Medicare and Medicaid Services (CMS) with the February 2001 renewal.

  This amendment adds the §1915(i)authority for ABA services to the procurement plan for PIHPs.

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)

- **Sole source** procurement
- **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
The State's request asked for a waiver of Sections 1902(a)(10)(B) and 1902(a)(23) of the Act.

The June 1998 approval letter for the first Medicaid Waiver period required that the State provide a detailed plan to shift from sole source procurement for its Prepaid Health Plan contracts to a full and open competitive procurement process which complied with the Federal procurement rules at 45 CFR Part 74. The State submitted a "Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans" in September 2000. This plan raised expectations for CMHSP's performance and included a requirement that PIHPs have at least 20,000 Medicaid beneficiaries in their service areas. CMS subsequently approved the renewal application and plan on February 20, 2001. During the second waiver period, MDCH completed the procurement process to establish PIHPs. The keystone of the implementation process was the Application for Participation (AFP). The AFP outlined the application process and required standards. AFP requirements were based on values that reflect person-centered planning; included the conditions of the approval in the February 20, 2011 letter from HCFA; and assured that regulations specified in the Balanced Budget Act for Medicaid Managed Care were met.

Applications submitted by CMHSPs in response to the AFP demonstrated that the CMHSP was able to meet, or had a viable plan with specified dates for completion to meet the standards. In addition, CMHSPS with geographic service areas serving fewer than 20,000 Medicaid beneficiaries formed affiliations to become a PIHP.
As a result of the procurement process, 18 CMHSPs began serving as PIHPs for Medicaid Specialty Services and Supports on October 1, 2002. Of the 18 PIHPs, 10 are PIHPs formed by affiliations of CMHSPs and 8 are "stand-alone" CMHSPs.

This amendment adds coverage of ABA services under the §1915(i) authority for children between the ages of 18 months through five years who have been diagnosed with Autism Spectrum Disorder and meet the needs-based eligibility criteria to receive ABA services. The need-based criteria is outlined in the §1915(i) State Plan Amendment.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. **Assurances.**
   - ☑ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
     - ☑ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

       MDCH assures access to services and choice of providers through its contract with PIHPs at Section 3.0 Access Assurance, and assures that PIHPs have adequate capacity to serve the needs of beneficiaries at Section 6.4 Provider Network Services.
2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

   Program: " **Managed Specialty Services and Supports Program.** *"*
   - ☐ **Two or more MCOs**
   - ☐ **Two or more primary care providers within one PCCM system.**
   - ☐ **A PCCM or one or more MCOs**
   - ☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**

please describe

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. **Rural Exception.**

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting.**

◉ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

The service areas (counties) for each PIHP are listed in the chart at Section A, Part I:Program Overview, D Geographic Areas, 2. Details

○ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Each PIHP is contractually obligated to serve all eligible beneficiaries, including children ages 18 months through 5 years, diagnosed with ASD who are eligible for ABA services under the §1915(i)authority, in its catchment areas who need specialty services and is required to make public information available to their citizenry concerning the services they provide. The State will contractually require the PIHP to add specific language as dictated by the State regarding the ABA benefit to the customer services handbook which is distributed to the citizenry annually. This will be included in the MDCH contract with the PIHP.

Beneficiaries receiving services covered by this Waiver may not enroll or seek services in another PIHP. However, for specific services within the PIHP network, the beneficiary may choose from among a range of available network providers, and may change providers within the PIHP. In addition, in some special circumstances, a beneficiary may wish to receive services from a provider that is part of another PIHP's provider network. In these situations, the PIHP may make arrangements to contract with that provider. A beneficiary may discontinue the services of a PIHP at any time, and then later return to the PIHP for restoration of services. The beneficiary may also move from one PIHP service area to another and will be considered transferred to the PIHP that serves the area to which the beneficiary relocates. Compliance with choice of providers is assessed during Department on-site reviews of each PIHP.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

- **Statewide** -- all counties, zip codes, or regions of the State
  -- *Specify Program Instance(s) for Statewide*
  - [x] **MSS&S Program**
- **Less than Statewide**
  -- *Specify Program Instance(s) for Less than Statewide*
  - [ ] **MSS&S Program**

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Bay, Arenac, Huron, Tuscola, Montcalm, Shiawassee	PIHP	Access Alliance of Michigan
Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	PIHP	CMH for Central Michigan
Clinton, Eaton, Ingham, Gratiot, Ionia, Newaygo, Manistee, Benzie	PIHP	CMH Affiliation of Mid-Michigan
Wayne	PIHP	Detroit-Wayne County CMH Agency
Genesee	PIHP	Genesee County CMH Services
Muskegon, Ottawa	PIHP	Lakeshore Behavioral Health Alliance
Kent	PIHP	network180
Jackson, Hillsdale	PIHP	LifeWays
Macomb	PIHP	Macomb County CMH Services
see additional information for listing of counties	PIHP	Northern Affiliation
see additional information for listing of counties	PIHP	Northwest CMH Affiliation
see additional information for listing of counties	PIHP	NorthCare
Oakland	PIHP	Oakland County CMH Authority
Saginaw	PIHP	Saginaw County CMH Authority
Lenawee, Livingston, Monroe, Washtenaw	PIHP	CMH Partnership of Southeast Michigan
Allegan, Cass, Kalamazoo, St. Joseph	PIHP	Southwest Affiliation
Lapeer, St. Clair, Sanilac	PIHP	Thumb Alliance PIHP
Barry, Berrien, Branch, Calhoun, Van Buren	PIHP	Venture Behavioral Health

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Northern Affiliation PIHP includes Antrim, Alcona, Alpena, AuSable, Charlevoix, Cheboygan, Emmet, Iosco, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, and Presque Isle Counties.

Northwest CMH Affiliation includes Crawford, Grand Traverse, Lake, Leelanau, Mason, Missaukee, Oceana, Roscommon and Wexford counties.

NorthCare PIHP includes Alger, Baraga, Chippewa, Delta, Dickinson, Houghton, Iron, Gogebic, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon and Schoolcraft counties.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

☑ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.
- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Other** (Please define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☑ **Reside in Nursing Facility or ICF/MR** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☑ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☑ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

☐ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

☑ **Other** (Please define):
Individuals enrolled in the Habilitation Supports Waiver and those in the MIChoice Waiver may also be enrolled in this waiver; however, individuals enrolled in Michigan's Children's Waiver Program and Children with Serious Emotional Disturbance Waiver are excluded.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Medicare beneficiaries may voluntarily participate in this Waiver. If they do participate, they may still obtain Medicare covered services from the provider of their choice. Depending on the beneficiary's particular status (category) as a dually-eligible beneficiary, his/her co-insurance and deductible for Medicare specialty services will be paid by the responsible PIHP. Medicare beneficiaries who require Medicaid only specialized services will have their Medicaid only services provided under this Waiver.

Native American Indian beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by MDCH under the memorandum of agreement (MOA) as specified in the Michigan Medicaid Provider Manual. If the IHS facility or THC provides services to non-Native American persons, the IHS facility or THC must become part of the PIHP provider panel in order to receive reimbursement for specialty services provided to non-Native American persons from the PIHP. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this Waiver through the PIHP. The PIHPs have been specifically instructed by MDCH to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

☑ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51 (b)

☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☑ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☑ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

   The PIHPs do not cover emergency medical services because those are the responsibility of the Medicaid health care providers. The PIHP covers services to resolve a crisis situation/condition involving the need for mental health, developmental disabilities or substance abuse services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

   ☐ Other (please explain):

   ☑ Family planning services are not included under the waiver.

   Family Planning Services Category General Comments (optional):

   The PIHP does not cover family planning services because those are the responsibility of the Medicaid health care providers.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

   ☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

   ☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

   ☑ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

   FQHC Services Category General Comments (optional):

   Beneficiaries have the right to receive services at FQHCs to the extent they are available (not all areas of the State are covered by FQHCs). However, FQHCs do not provide specialty services and supports, only PIHPs do so.

5. **EPSDT Requirements.**

   ☑ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

   EPSDT Requirements Category General Comments (optional):

   PIHPs do not generally conduct initial core EPSDT screening activities. The basic EPSDT screening activities, including the comprehensive health and developmental history and assessments of mental development, are typically performed first by other entities or practitioners, including the Medicaid Health Plans, primary care physicians, health departments, etc. Based on these preliminary assessments, Medicaid policy requires that the primary care provider should determine whether to refer the beneficiary to the specialty PIHP for more specialized assessment of mental development or for corrective specialty treatment related to a need that has been identified by the primary screening activity.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. **1915(b)(3) Services.**

   ☑ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

   1915(b)(3) Services Requirements Category General Comments:

Michigan's 1915(b)(3) services were approved by CMS as part of the 2003 waiver renewal. Subsequently, CMS RO approved the definitions of each service. The 15 1915(b)(3) services for mental health and developmental disabilities are available to all Medicaid beneficiaries with mental illness or developmental disabilities who also meet the criteria for specialty services and supports, and for whom the services are medically necessary. Two 1915(b)(3) services are available only to individuals with substance use disorders. The 1915(b)(3) services are required to be available in every PIHP area and are managed by the PIHP who in turn directly deliver the services or subcontract with their provider networks. The funding for 1915(b)(3) services is included in each PIHP's managed care capitation payment.

1915(b)(3) Service Expenditures FY10

Provider Name	MHB3	SAB3	Total B3	% of Total
ACCESS ALLIANCE	25,520,284.59	448,112.09	25,968,396.68	3.82%
CMH AFFILIATION OF MID MI	35,448,216.24	481,563.52	35,929,779.76	5.28%
CMH FOR CENTRAL MICHIGAN	18,317,232.21	253,577.52	18,570,809.73	2.73%
CMH PARTNERSHIP OF SE MI	30,005,763.33	558,976.17	30,564,739.50	4.49%
DETROIT WAYNE PIHP	149,270,972.35	3,961,437.36	153,232,409.71	22.53%
GENESEE COUNTY PIHP	35,800,642.68	1,081,946.15	36,882,588.83	5.42%
LAKESHORE BEHAVIORAL HLTH ALLIANCE	24,038,315.24	463,302.23	24,501,617.47	3.60%
LIFEWAYS PIHP	13,555,934.96	274,245.03	13,830,179.99	2.03%
MACOMB PIHP	55,063,817.48	1,054,945.60	56,118,763.08	8.25%
NETWORK 180	36,908,288.92	679,724.15	37,588,013.07	5.53%
NORTH CARE	26,662,081.48	295,309.31	26,957,390.79	3.96%
NORTHERN AFFILIATION	18,486,006.77	315,669.06	18,801,675.83	2.77%
NORTHWEST CMH AFFILIATION	18,456,764.25	281,361.70	18,738,125.95	2.76%
OAKLAND COUNTY PIHP	80,942,716.72	948,828.98	81,891,545.70	12.04%
SAGINAW COUNTY PIHP	14,869,151.64	438,930.13	15,308,081.77	2.25%
SOUTHWEST MI URBAN & RURAL CONS.	28,218,841.07	572,047.16	28,790,888.23	4.23%
THUMB ALLIANCE	24,257,289.56	328,783.71	24,586,073.27	3.62%
VENTURE BEHAVIORAL HEALTH	31,176,632.02	549,221.04	31,725,853.06	4.67%
Grand Total	666,998,951.51	12,987,980.91	679,986,932.42	100.00%

1915(b)(3)SERVICES
Assistive Technology
Community Living Supports
Enhanced Pharmacy
Environmental Modifications
Family Support and Training
Fiscal Intermediary Services
Housing Assistance
Peer-Delivered or -Operated Support Services
Prevention-Direct Service Models
Respite Care Services
Skill-Building Assistance
Support and Service Coordination
Supported/Integrated Employment Services
Wraparound Services for Children and Adolescents

SUBSTANCE ABUSE SERVICES (B)(3)s
Sub-Acute Detoxification
Residential Treatment

A full definition of these (b)(3) services and authorization criteria can be found in Section 17 and 18 of the Mental

Health/Substance Abuse Chapter of Michigan's Medicaid Provider Manual. The manual can be found on-line at: http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf .

7. **Self-referrals.**

☑ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Beneficiaries may self-refer and receive crisis intervention and intensive crisis stabilization services without prior authorization.

8. **Other.**

☑ Other (Please describe)

Please note that the State is eliminating the (b)(3) service Crisis Observation Care due to lack of utilization.

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. **Assurances for MCO, PIHP, or PAHP programs**

☑ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   a. ☐ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.
      1. ☐ PCPs

         Please describe:

      2. ☐ Specialists

         Please describe:

      3. ☐ Ancillary providers

         Please describe:

      4. ☐ Dental

         Please describe:

      5. ☐ Hospitals

         Please describe:

      6. ☐ Mental Health

         Please describe:

      7. ☐ Pharmacies

         Please describe:

      8. ☐ Substance Abuse Treatment Providers

         Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:
For all services provided by the PIHPs and their associated networks, statewide access and capacity must be assured. In this respect, the proposed ABA service is no different. MDCH and the PIHPs are responsible for monitoring the provider network through utilization data, appeals, and grievances, monitoring of denials or reductions in service in order to assure that the ABA benefit is provided statewide.

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☑ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the State's standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)
   - **f.** ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

   - **g.** ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
The MDCH and PIHPs are actively engaged in providing training opportunities for professionals in the diagnostic tools to identify children between the ages of 18 months through 5 years with ASD and those trained professionals will also apply the needs-based criteria through the Independent Assessment for the ABA benefit. There are qualified providers at each PIHP who can complete the Independent Evaluation, participate in the development of the plan of service (individual plan of service or IPOS) and oversee the delivery of ABA services for this small group of Medicaid beneficiaries between the ages of 18 months through 5 years.

The PIHPs are presently engaged in developing workforce capacity, accessing trainings for staff that the State has offered in conjunction with expert organizations (e.g., Sunfield Center) including universities (e.g., University of Michigan) regarding the assessment tools such as the ADOS and the ADI-R and training regarding autism and ABA. The PIHPs are also partnering with experts to develop their own trainings to assure sufficient qualified staff.

The State has established provider qualifications to include a phase-in period until September 30, 2016 for capacity building that enables qualified professional staff to provide ABA services while obtaining the additional certification required as a Board Certified Behavior Analyst (BCBA) or Assistant Behavior Analyst (BCaBA). Criteria for supervision of these professionals are specified in the §1915(i) SPA.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. **Assurances for MCO, PIHP, or PAHP programs**

☑ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

a. ☑ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

This Waiver covers all categories of Medicaid beneficiaries (children and adults) who require specialty services and supports due to serious mental health needs, substance disorders, and/or developmental disabilities. Eligibility criteria (diagnostic, functional, impairments, level of service need, and medical necessity) for specialty services are defined in State Medicaid policy and/or state statute.

For the purposes of the Specialty Services and Supports Waiver that provides only mental health, developmental disabilities and substance abuse services, Michigan defines individuals with special health care needs as those who have chronic medical conditions. Such individuals' special health care needs are met through the Medicaid Health Plans (MHPs) if they are enrolled in same, or by fee-for-services Medicaid if not enrolled. It is the PIHP's responsibility to coordinate the care of people with special heatlh care needs with the MHPs.

b. ☐ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

c. ☐ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

d. ☐ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☐ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. ☐ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   - **b.** ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   - **c.** ☐ Each enrollee is receives **health education/promotion** information.

     Please explain:

   - **d.** ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   - **e.** ☐ There is appropriate and confidential **exchange of information** among providers.
   - **f.** ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
   - **g.** ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   - **h.** ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

☑ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

06/23/98 *(mm/dd/yy)*

The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	Health Services Advisory Group	Compliance with all managed care standards	BBA Compliance Monitoring Validation of Performance Measures Validation of Performance Improvement Projects	none

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
   - **a.** ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

     Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **b.** ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
     1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
     2. ☐ Initiate telephone and/or mail inquiries and follow-up
     3. ☐ Request PCCM's response to identified problems
     4. ☐ Refer to program staff for further investigation
     5. ☐ Send warning letters to PCCMs
     6. ☐ Refer to State's medical staff for investigation
     7. ☐ Institute corrective action plans and follow-up
     8. ☐ Change an enrollee's PCCM
     9. ☐ Institute a restriction on the types of enrollees
     10. ☐ Further limit the number of assignments
     11. ☐ Ban new assignments
     12. ☐ Transfer some or all assignments to different PCCMs
     13. ☐ Suspend or terminate PCCM agreement
     14. ☐ Suspend or terminate as Medicaid providers
     15. ☐ Other

     Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **c.** ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
     Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   - **A.** ☐ Initial credentialing
   - **B.** ☐ Performance measures, including those obtained through the following (check all that apply):
     - ■ ☐ The utilization management system.
     - ■ ☐ The complaint and appeals system.
     - ■ ☐ Enrollee surveys.
     - ■ ☐ Other.

       Please describe:
4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other

   Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

   d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1.

- [x] The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. [ ] The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

3. [ ] The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. **Details** (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.

☐ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☐ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

☐ The languages comprise all languages in the service area spoken by approximately _____ percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
Each PIHP is contractually obligated to serve all eligible beneficiaries in its catchment area who need specialty services and is required to make public information available to their citizenry concerning the services they provide. The information they provide is not for the purpose of attracting additional "enrollees", but is intended to acquaint beneficiaries with the availability of services.

In 2007, MDCH implemented standards for customer services handbooks. MDCH requires each PIHP to submit their Customer Services handbook for review and approval. PIHPs are also required to submit proposed revisions to MDCH for review and approval.

The customer services standards and handbook template can be found on the MDCH website at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, then Mental Health and Developmental Disabilities, then Customer Services. Alternatively, the direct address is http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_44561---,00.html .

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. **Assurances**

- [x] The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. **Details**

   a. **Non-English Languages**

      1.

- [x] Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

The State does not specify the languages into which materials should be translated but does contractually require the PIHPs to make materials available in any language required to comply with the Limited English Proficiency Policy Guideline (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002.)

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b.

☐ The languages spoken by approximately percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☑ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Accomodations, including oral translation services, are contractually required to be available through customer services at each PIHP.

3. ☑ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The State mails a brochure annually to each Medicaid beneficiary and each new enrollee that describes the specialty mental health services. In addition, the brochure is posted on the MDCH website. Effective October 1, 2007, all PIHPs were required to use standard language in their customer services handbooks.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State
☐ Contractor

Please specify:

☑ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. **Details** (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

☑ the State
☐ State contractor

Please specify:

☑ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

There is no choice of plans since there is only one PIHP in each service area and fee-for-service is not an option.

Beneficiaries receiving services covered by this Waiver may not enroll or seek services in another PIHP. However, for specific services within the PIHP network, the beneficiary may choose from among a range of available network providers, and may change providers within the PIHP. In addition, in some special circumstances, a beneficiary may wish to receive services prom a provider that is part of another PIHP's

provider network. In these situations, the PIHP may make arrangements to contract with that provider. A beneficiary may discontinue the services of the PIHP at any time, and then later return to the PIHP for reconsideration of services. The beneficiary may also move from one PIHP service area to another and will be considered transferred to the PIHP that serves the area to which the beneficiary relocates.

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☑ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The State mails a brochure annually to each Medicaid beneficiary and each new enrollee that describes the specialty mental health services. In addition, the brochure is posted on the MDCH website.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☑ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. **Details** (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i.

☐ Potential enrollees will have ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☑ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☑ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of _____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☐ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☐ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☐ Enrollee submits request to State.
- **ii.** ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☑ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of _____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- **i.** ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

☑ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☑ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

    ☑ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

    Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

    ☑ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

    a. Direct Access to Fair Hearing

    ☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
    ☑ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

    b. Timeframes

☑ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 90 days (between 20 and 90).

☑ The State's timeframe within which an enrollee must file a **grievance** is 60 days.

c. Special Needs

☑ The State has special processes in place for persons with special needs.

Please describe:

PIHPs are required to provide beneficiaries reasonable assistance to complete forms and take procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):
The grievance procedures are operated by:

- ☐ the State
- ☐ the State's contractor.

  Please identify: _____
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.
☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.
☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. **Assurances**

☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☑ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915 (b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

- [x] The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- [x] State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☑ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ FFS	☐ FFS	☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO	☐ MCO	☐ MCO

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☑ PIHP ☐ PAHP	☐ MCO ☑ PIHP ☐ PAHP	☐ MCO ☑ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
MSS&S Program	PIHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Managed Specialty Services and Supports Program

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

c. ☑ **Consumer Self-Report data**

Activity Details:

MDCH conducts comprehensive biennial site visits to all PIHPs. In the year following a comprehensive review PIHPs are visited by state staff to follow up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy incorporates for all beneficiaries served by the specialty waiver the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive reviews include:

a)Consumer/Stakeholder Meetings
During the biennial comprehensive review, the team meets with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered planning, self -determination, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

b)Consumer Interviews
Review team members conduct interviews with a sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning, independent facilitation of person-centered planning, self-determination arrangements and individual budgets, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews are conducted where consumers live and in a variety of other locations including PIHP offices, service sites or over the telephone.

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:
A. Encounter and Quality Improvement Data - Demographic characteristics as well as summary encounter data are reported to MDCH for each mental health service recipient. Individual level demographic data and admission and discharge records for persons receiving substance abuse treatment services have been collected since 1980. Data are stored in the same MDCH data warehouse as Medicaid Health Plan and Pharmacy encounter data. MDCH BHDDA staff analyze mental health, substance abuse, pharmacy and health plan data to evaluate appropriateness of care, over- and under-utilization of services, access to care for special populations, and the use of state plan service versus 1915(b)(3) services. Aggregate data from the encounter data system are shared with MDCH BHDDA Management Team, the Encounter Data Integrity Team (EDIT), and with the QIC.

B. Medicaid Utilization and Net Cost Data - PIHPs are required to submit Medicaid Utilization and Net Cost Reports annually. These reports provide numbers of cases, units, and costs for each covered service provided by PIHP and include the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. MDCH uses the data to verify the completeness and accuracy of the encounter data. Cost data are shared with the MDCH BHDDA Management Team, EDIT, the State's actuary, and the QIC.

C. Event Reporting System - In FY09-10 MDCH completed work on implementing a new critical incident reporting system that provides more timely information on critical incidents. Unlike the old aggregated sentinel event data collection system it was designed to replace, the new event reporting system collects data on events that can be linked to specific service recipients. This system became fully operational and contractually required October 1, 2010.

The Event Reporting System captures data on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and consumer arrest. The populations on which these events must be reported differs slightly by type of event. Suicides are reported for a broader population (any consumer who is actively receiving services) than emergency medical treatment (consumers residing in specialized residential settings, child caring institutions, and consumers receiving Habilitation Supports Waiver, Children's Waiver, or SED Waiver services).

The Department has developed formal procedures for analyzing the submitted data. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up.

D. Recipient Rights - Local CMHSP Recipient Rights offices report semi-annually summaries of numbers of allegations received, number investigated, number in which there was an intervention, and the numbers that were substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state Office of Recipient Rights and submitted to stakeholders and the Legislature. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH MH&SA Management Team and with the QIC.

E. Appeals and Grievances Mechanisms - CMS approved the BBA revision of the appeals and grievance procedures, required by MDCH/PIHP contract. The EQR reviews the process for providing information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Appeals Fair Hearings database to track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the EQRs are shared with MDCH BHDDA Management Team and with the QIC.

For each of these data sources, information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- [ ] **Denials of referral requests**
- [ ] **Disenrollment requests by enrollee**
  - [ ] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [ ] **Other**

Please describe:

e. [ ] **Enrollee Hotlines**

Activity Details:

f. [ ] **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☑ **On-Site Review**

Activity Details:

MDCH conducts comprehensive biennial site visits to all PIHPs. During the alternate years PIHPs are visited by state staff to follow up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy incorporates for all beneficiaries served by the specialty waiver the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive reviews include the following components:

A. Clinical Record Review

Reviews of clinical records to determine that 1) person-centered planning is being utilized; 2) access to and information about independent facilitation of person-centered planning is made available; 3) access to, information about, and supports for self-determination, including individual budgets, is made available; 4) health and welfare concerns are being addressed if indicated; 5) services identified in the plan of service are being delivered; and 6) delivery of service meet program requirements that are published in the Medicaid Provider Manual. Random samples of clinical records to be reviewed are drawn by the MDCH review team. Limited advanced notice is provided to PIHPs about the records selected for review. An additional set of randomly selected records is requested without advance notice after the team has arrived on-site. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs, all affiliates (if applicable), a sample of providers, and an over-sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

B. Administrative Review

The comprehensive administrative review focuses on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH/PIHP contract requirements and include:

o Compliance with the Medicaid Provider Manual

o Written agreements with providers, community agencies
o The results of the PIHPs' annual monitoring of its provider network
o Adherence to contractual practice guidelines
o Sentinel event management

C. Consumer/Stakeholder Meetings
During the biennial comprehensive review, the team meets with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered planning, self -determination, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

D. Consumer Interviews
Review team members conduct interviews with a sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning, independent facilitation of person-centered planning, self-determination arrangements and individual budgets, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews are conducted where consumers live and in a variety of other locations including PIHP offices, service sites or over the telephone.

A report of findings from the on-site reviews with scores is disseminated to the PIHP with requirement that a plan of correction be submitted to MDCH in 30 days. Reports on plans of correction are submitted to MDCH. On-site follow-up is conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Overall PIHP site review responsibility is located in the Division of Program Development, Consultation and Contracts. The PIHP site review team is currently composed of: two registered master's degreed nurses, a licensed master's social worker, two analysts, and two individuals who have a mental illness and meet the qualifications for, and are employed as, analysts. The Office of Mental Health Services to Children and Families provides additional staff to conduct the Children's Waiver portion of the review.

m. ☑ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:
The BHDDA Management Team, the QIC, and Division of Quality Management and Planning staff collaborate to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, EQR findings, and stakeholder concerns.
For the upcoming waiver period Michigan will require all PIHPs to conduct a minimum of two performance improvement projects:
a. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH. In the case of PIHPs that are composed of more than one CMHSP, the project covers the entire PIHP. The current statewide mandated performance improvement project is increasing the percentage of individuals who receive at least one peer delivered service or support.
b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, may be assigned a specific project topic relevant to the problem. At the present time, PIHPs were allowed to choose a second performance improvement project in consultation with their QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHP's methodologies for conducting the projects. Results of the MDCH performance improvement project reports are shared with MDCH BHDDA Management Team and with the QIC to review the outcomes of monitoring various aspects of the quality strategy. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- [x] **Clinical**
- [ ] **Non-clinical**

n. [x] **Performance Measures** [Required for MCO/PIHP]

Activity Details:

Medicaid Performance Indicators measure performance aspects of the PIHPs and are extracts from the Michigan Mission-Based Performance Indicator System that has evolved since 1997. The indicators are categorized by domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to suggest that there are trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in the MDCH data warehouse. Any data that are submitted by PIHPs, and the methodologies for doing so, are validated by MDCH and the EQR. Analyses of the data result in comparisons among PIHPs and with statewide averages. Statistical outliers are determined for the identification of best practices or conversely, opportunities for improvement. Entities found to have negative statistical outliers in more than 2 consecutive periods are the focus of investigation, leading up to PIHP contract action. Technical information from the performance indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH BHDDA Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- [ ] **Process**
- [ ] **Health status/ outcomes**
- [x] **Access/ availability of care**
- [ ] **Use of services/ utilization**
- [ ] **Health plan stability/ financial/ cost of care**
- [ ] **Health plan/ provider characteristics**
- [ ] **Beneficiary characteristics**

o. [ ] **Periodic Comparison of # of Providers**

Activity Details:

p. [ ] **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. [ ] **Provider Self-Report Data**

Activity Details:

- [ ] **Survey of providers**
- [ ] **Focus groups**

r. [ ] **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☑ **Other**

Activity Details:
EXTERNAL QUALITY REVIEW

For FY12 MDCH will continue to contract with Health Services Assessment Group (HSAG) to conduct the EQR State contracting requirements will necessitate re-bidding the EQR contract for FY'13 and 14. The BBA compliance monitoring portion of the EQR consists of desk audits of PIHP documents and also includes either a two-day on-site visit or telephone conference with each PIHP. The decision to conduct an on-site review versus a telephone conference is based on past PIHP performance on the EQR BBA compliance monitoring reviews.

The contents of the review for FY' 12-14 are:
a. Validation of Performance improvement projects:
i.For FY'12-14, the EQR will focus on the methods PIHPs employed to implement the MDCH-required project – Increasing the proportion of Medicaid eligible adults with mental illness who receive at least one peer-delivered service or support. The PIP validation process included reviews of the following activities:
1. Choosing the study topic
2. Defining the study questions
3. Selecting the study indicators
4. Using a representative and generalized study population
5. Using sound sampling methods
6. Using valid and reliable data collection procedures
7. Including improvement strategies and implementing interventions
8. Describing data analysis and interpreting study results

b. Validation of performance indicators:
i. In FY'12-14 EQR will look at data collection methods for all fifteen performance indicators and perform an ISCAT.
ii. EQR will review the results for each indicator and note areas for improvement and areas of strength for each PIHP.

c. Compliance with Michigan's Quality Standards per BBA:
i. In FY'12-13 the EQR will focus on reviewing compliance with the following standards:
1. QAPIP and Structure
2. Performance Measurement and Improvement
3. Practice Guidelines
4. Staff Qualification and Training
5. Utilization Management
6. Customer Services
7. Recipient Grievance Process
8. Recipient Rights and Protections
9. Subcontracts and Delegation
10. Provider Network
11. Credentialing
12. Access and Availability
13. Coordination of Care
14. Appeals

ii. In FY'13-14, the EQR will focus on following up on any problems identified in the FY 12-13 review cycle.
In FY'12 the EQR will conclude its optional activity to study SMI-DD Coordination of Care/Medical Service Utilization.

Results of the EQRs are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

- ○ **This is the first time the State is using this waiver format to renew an existing waiver.** The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ◉ **The State has used this format previously** The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Consumer Self-report

The site review team conducted 1126 interviews with consumers and/or family members from Oct 2009-Apr 2011. Five more PIHP reviews are scheduled to be completed before Sept 30, 2011. Issues identified in the consumer interviews corroborated findings noted in clinical record reviews. Interviews showed a high degree of satisfaction with services and supports. Individuals confirmed that essential elements of person-centered planning are occurring and that their health and safety concerns are being addressed in service planning and delivery.

Data analysis

a) Grievances and Appeals Data

No systemic problems have been identified. Only a small number of the Fair Hearing requests result in a formal hearing decision. The overwhelming majority was settled before getting to a hearing or was dismissed.

b) Sentinel Events Data

MDCH staff follow up on reported sentinel events to help ensure data collection and reporting consistency. Nurses from MDCH's site review team also evaluate each PIHP's sentinel event root cause analysis process. No systemic problems have

been found with regards to sentinel events.

On-site review
During the current Waiver period, the MDCH site review team will conduct full and follow-up reviews on each of the 18 PIHPs. Thus far in the current Waiver period, the MDCH site review team has reviewed over 2,000 clinical records for compliance with a standard set of protocols.

Overall PIHP site review performance has continued to improve with each review cycle. Although there were no discernable system-wide problems found consistently at each PIHP for specific individual review dimensions, there were some subject areas where PIHP's failed to achieve full compliance. These included the areas of provider monitoring, quality improvement, and health and safety and plan of service documentation.

Performance Improvement Projects
During the Oct 2009 to Sept 2011 time period, the PIHPs completed one set of PIPs. A second set began in Jan 2011. The MDCH-mandated PIP topic for the first set was Improving the Penetration Rates for Children. The MDCH-mandated PIP topic for the second set was Increasing the Percentage of Individuals Receiving a Peer-delivered Support or Service.
The MDCH-mandated PIP was also reviewed by Health Services Advisory Group (HSAG) as part of the external quality review. Each of the 18 PIHPs received a "met" validation status for their PIPs for the most recent time period.

Performance Measures
During FY '09 HSAG validated eleven mental health performance indicators and one substance abuse indicator for each PIHP. Seventeen PIHPs were either fully valid or substantially valid on all twelve indicators. The remaining PIHP was evaluated as 'not valid' on just one of their indicators. HSAG noted improvement across many of the PIHPs in regard to better validation of the data and indicators, clearer documentation on how the indicators were calculated and greatly improved adherence to MDCH's codebook instructions.

External Quality Review
For the Oct 2009 to Sept 2011 review period Health Services Advisory Group (HSAG) conducted a follow-up review on compliance with all applicable BBA standards.
After the follow-up review, the statewide average of the PIHP's scoring for all BBA compliance monitoring standards ranged from 98% to 100%. PIHP performance on BBA compliance related measures remains quite strong.

Service Agency Profiles
With isolated exceptions, the site review team has found that the database contains current service agency profile information. There are occasional instances where service agency profile information has not been submitted or is not current.

MDCH Approval of Customer Services Handbooks
MDCH has continued to review and approve any substantive modifications to each of the PIHP's customer services handbooks.

Application for Participation (AFP)
In 2002 the State reviewed the 18 PIHPs' provider network configuration, selection and management. PIHPs were also required to attest to meeting the standards, submit supportive documentation, and provide verification of the attestation during AFP site reviews from the state. Continuing compliance, including recruitment and retention of direct provider panel networks, is monitored through the site review process. Isolated problems with PIHPs not having a specific program required as part of the continuum of services have been successfully addressed via site review and contract management activities.

Service Agency Profiles
PIHPs are required to submit updated service agency profile information as part of their site review corrective action plan if they have failed to update or provide this information as required. Each CMHSP is required to review and resubmit their entire service agency profile as part of the Mental Health Code mandated certification process.

Application for Renewal and Recommitment (ARR)
In Feb 2009 MDCH issued an "Application for Renewal and Recommitment" The ARR is based on a quality improvement model for the process of delivering supports and services, the environment in which they are delivered, and their outcomes for Medicaid beneficiaries. The ARR also provides clear direction that PIHPs must increase stakeholder involvement in all aspects of their organizations. PIHPs submitted responses to the ARR that described the results of their local environment scans on how well they were achieving each area of the ARR, as well as plans for improvement. MDCH staff reviewed the

responses and provided feedback to the PIHPS. MDCH staff members have continued to follow-up and provide technical assistance and consultation.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Please see D.1. worksheet for enrollment information	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**				
Enrollment Projections for the Time Period*				
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Refer to Appendix D2.S of Appendices D1-7 for identification of state plan and (b)(3) services	☐	☐	☐	
	☐	☐	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature: Stephen Fitton

State Medicaid Director or Designee

Submission Date: Mar 19, 2013

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Nick Lyon

c. Telephone Number:

(517) 241-1193

d. E-mail:

LyonN2@michigan.gov

e. The State is choosing to report waiver expenditures based on

- (●) **date of payment.**
- ( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- **b.** [x] The State provides additional services under 1915(b)(3) authority.
- **c.** [ ] The State makes enhanced payments to contractors or providers.
- **d.** [x] The State uses a sole-source procurement process to procure State Plan services under this waiver.
- **e.** [ ] The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

- **a.** ☐ **MCO**
- **b.** ☑ **PIHP**
- **c.** ☐ **PAHP**
- **d.** ☐ **PCCM**
- **e.** ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- **a.** ☐ **Management fees are expected to be paid under this waiver.**

  The management fees were calculated as follows.

  1. ☐ **Year 1: $ per member per month fee.**
  2. ☐ **Year 2: $ per member per month fee.**
  3. ☐ **Year 3: $ per member per month fee.**
  4. ☐ **Year 4: $ per member per month fee.**

- **b.** ☐ **Enhanced fee for primary care services.**

  Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

- **c.** ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

- **d.** ☐ **Other reimbursement method/amount.**

  $

  Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☑ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☐ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☑ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
The actual R1 to R2 and the projected R2 to P2 increase in member months is attributable to growth in Medicaid eligibles, which are the "covered lives" under the waiver program. While there has been some improvement in the State's economy, there is still growth in Medicaid eligibles related to workforce downsizing, loss of private insurance, etc., and in part due to the state's enhanced Medicaid information and outreach efforts.

d. ☐ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

e. ☑ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
SFY

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☑ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

Different services are not included in the Actual Waiver Costs as reflected in Appendix D3 and Appendix D5. However, it should be noted that the State followed CMS' consultation to move the reporting of EPSDT service costs for individuals under the age of 21 from (b)(3) to state plan services.

Beginning April 1 2013, ABA services under the §1915(i) authority is being added for ages 18 months through 5 years who are diagnosed with ASD via an amendment to this waiver.

b. ☑ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

No Managed Specialty services or supports are excluded from the CE analysis. Each 1915(b) waiver reports on separate CMS 64.9 Waiver forms and separate lines of the Waiver summary forms.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Refer to Appendix	☐	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
D2.S of Appendices D1-7 for identification of state plan and (b)(3) services							
	☐	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☑ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☑ **Other**

Please explain:

There is no fee for service coverage for any of the benefits covered under the managed specialty services and supports program, except for the coverage of ABA services as prescribed under the §1915(i) authority. The state administrative costs included in Appendix D2.A are limited to MMIS, MDCH/State staffing (CAP), External Quality Review, fees for claims and rebates processing and DUR for the fee for service psycho-pharmaceutical benefits "impacted" by PIHPs contracted under this waiver, and professional contracts associated with the administration of the specialty managed care program. All administrative costs have been allocated to the managed care MEGs listed herein on a PMPM basis.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☑ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5.**

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Refer to Appendix D2.S of Appendices D1-7 for identification of state plan and (b)(3) services			
Total:	$679,808,272 in R1 and $740,839,026 in R2, totaling $1,420,647,299 From Appendix D.3	-7.2% yr R2 to P1; 1.1% yr P1 to P2	$720,685,113 in P1, $763,295,586 in P2

b. ☐ **The State is including voluntary populations in the waiver.**

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☑ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ☑ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☑ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☑ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

   The State has reserved a total of $225,000 to use as monetary incentives in addition to capitated payments. The $225,000 monetary incentive is included within any one PIHP's 5% incentive cap. A first and second place monetary award will be presented to a PIHP who has shown a relative improvement over the last fiscal year in the following areas:
   1) Overall number of consumers engaged in meaningful employment

2) Overall number of consumers who have a self-determination arrangement
3) Overall number of consumers discharged from a Substance Abuse detox unit and seen for follow up within 7 days

Prior to the implementation of FY12 contract, a group of PIHP representatives will convene to develop the process and procedures for the monetary incentive award under the 3 areas identified. These written procedures will be shared with the system. In order to be eligible for the award, a PIHP must not have received a non-compliance score for any site review dimension in their site review report.

The size and limit of the incentive payments are such that total payments to a PIHP will not exceed the Waiver Cost Projection.

MDCH will use an additional monetary incentive payment to increase access and intensity (amount, scope and duration) of specialty mental health service and supports for children of the highest need served by the Michigan Department of Human Services (MDHS) in the child welfare system. MDHS has provided general fund dollars not to exceed $4,971,800 (FY 2012 - $2,095,900 and FY 2013 - $2,875,900) to use as monetary incentives in addition to Medicaid capitated payments. The monetary incentives for both FY 2012 and FY 2013 are included within any one PIHP's 5% incentive cap.
The PIHPs may qualify to receive only one of the two incentive payments per each identified Medicaid Eligible child (per month) that is also served in the DHS Foster Care System or Child Protective Services (Risk Categories I & II). Payment rates will be determined based on PHIPs providing services to those identified eligible children of the highest need based on one of the following criteria:
Service Criteria 1: At least one of the following services is provided in the eligible month:
a. H2021 – Wraparound Services, as outlined in the Medicaid Provider Manual
b. H0036 – Home Based Services, as outlined in the Medicaid Provider Manual
Service Criteria 2: Two or more state plan and/or 1915(b)(3) mental health services covered under the 1915(b) Specialty Supports and Services Waiver, excluding one-time assessments, were provided in the eligible month.

Incentive payments will only be made to children who are being served under the Specialty Services and Supports Waiver. Children being served under the 1915(c) Serious Emotional Disturbance Waiver or Childrens Waivers will not be eligible for incentive payments.

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

Document:

i. **Document the criteria for awarding the incentive payments.**
ii. **Document the method for calculating incentives/bonuses, and**
iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☑ **[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is: 0.33

   Please document how that trend was calculated:

   The state plan inflation trend rates for the Base Year (R2) to the first projection year (P1) reflect the estimated increase in expenditures attributable to fee-for-service pharmacy expenditures. Capitation rate changes from R2 to P1 are reflected as a programmatic adjustment. Therefore, the pharmacy expenditures included in R2 are based on estimated, and not actual rebates. R2 to P1 trends specific to pharmacy costs are the following: 4.0% DAB, 6.0% TANF, and 8.0% MCHIP. The following table illustrates the state plan inflation trends included in Appendix D.5.

Meg	Inflation Adjustment
MCHIP	1.24%
TANF	0.85%
DAB	0.37%
Waiver (c)	0.00%

2. ☑ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☑ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   For state plan costs in P2, trend rates for capitated services were established based on historical cost changes observed in encounter and financial cost report data from fiscal years 2008 through 2010. The trend rates reflect estimated age/gender mix changes in each MEG during the projection period. Trend rates for pharmaceutical services were established based on historical growth from fiscal year 2008 through the first half of fiscal year 2011 and national

pharmaceutical trends. The actual estimated state plan inflation included in worksheet D.5. reflects the estimated cost mix between capitated and fee-for-service pharmacy costs, along with the monetary incentive payments.

ii. ☐ **National or regional factors that are predictive of this waiver's future costs.**

Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☑ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**

Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. **Please indicate the years on which the utilization rate was based (if calculated separately only).**
ii. **Please document how the utilization did not duplicate separate cost increase trends.**

The years on which the utilization rate was based are fiscal years 2010 and 2011.

ABA services are being added and were not previously covered under the State Plan, therefore duplication did not occur.

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☑ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☑ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.
The program adjustment from R2 to P1 reflects the changes to the Specialty Services Waiver capitation rates effective October 1, 2011. The rates will be effective through September 30, 2012.

The program adjustment for P2 reflects the addition of ABA benefit effective April 1, 2013 through December 31, 2013. The ABA benefit is a State Plan service offered under the §1915(i) authority.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☑ Other:
Please describe
The program adjustment from R2 to P1 reflects the changes to the Specialty Services Waiver capitation rates effective October 1, 2011. The rates will be effective through September 30, 2012.

The program adjustment for P2 reflects the addition of ABA benefit effective April 1, 2013 through December 31, 2013. The ABA benefit is a State Plan service offered under the §1915(i) authority.

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☑ Changes brought about by legal action:
Please list the changes.
A federal lawsuit was filed against MDCH to require MDCH to provide Medicaid coverage for ABA therapy for Medicaid eligible children diagnosed with ASD. MDCH is in the process of coming to a settlement agreement with the plantiffs.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☑ Other
Please describe

A federal lawsuit was filed against MDCH to require MDCH to provide Medicaid coverage for ABA therapy for Medicaid eligible children diagnosed with ASD. MDCH is in the process of coming to a settlement agreement with the plantiffs.

iv. ☑ Changes in legislation.

Please list the changes.
Michigan Legislature appropriated $17.5 million for the coverage of ABA services for Medicaid children diagnosed with autism spectrum disorders. The appropriated amounts are used for SFY 2013 and future sufficient appropriations are expected.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☑ Other
Please describe
Michigan Legislature appropriated $17.5 million for the coverage of ABA services for Medicaid children diagnosed with autism spectrum disorders. The appropriated amounts are used for SFY 2013 and future sufficient appropriations are expected.

v. ☐ Other
Please describe:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

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c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS)

costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☑ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

ii. ☑ Cost increases were accounted for.

A. ☑ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☑ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☑ State Historical State Administrative Inflation. THe actual trend rate used is PMPM
size of adjustment
4.70
Please describe:
The enhancements described in c.2.i. combined with the historical annual trend result in a R2 to P1 increase of 45.5%; from P1 through P2 the historical state administration annual inflation rate of 4.7% per year has been applied.

D. ☑ Other
Please describe:
The state administrative costs reflect the expected time MDCH employees will spend administering the ABA benefit. These cost have been allocated across various MEGs based on the expected number of beneficiaries in each MEG. These amounts are reflected in Appendix D5 of the worksheet in cells AC30-33.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from Section D.I.J.a. above

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d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☑ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1]
The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:
0.00
Please provide documentation.
Actual rate was -7.2. The trend rates for R2 to P1 were developed from a comparison of the actuarially sound capitation rates estimated for P1 relative to the actual R2 PMPMs. The update capitation rates were developed from FY09&10 encounter and financial cost report data, and reflect EPSDT services previously being classified as(b)(3)services in R2 switching to state plan classification.

2. ☑ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i.

A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years
FY08 through FY11 (Note: FY

2. Please provide documentation.

MEG	Annualized (B)(3) Growth
MCHIP	6.0%
TANF	7.9%
DAB	3.5%
Total	3.7%

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above
0.33

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

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p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915 (b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
  2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☑ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.

Please describe

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K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Please reference completed appendices and explanation provided in D.I.J. above.

Appendix D5 – Waiver Cost Projection

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L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Please reference D. Part I.E.c above.
Appendix D6 – RO Targets

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M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   The actual R1 to R2 and the projected R2 to P2 increase in member months is attributable to growth in Medicaid eligibles, which are the 'covered lives' under the waiver program. The growth in the Medicaid population is due to the continued decline of the state's economy, with its related workforce downsizing, loss of private insurance, etc., and in part due to the state's enhanced Medicaid information and outreach efforts.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   The state plan inflation trend rates for the Base Year (R2) to the first projection year (P1) reflect the estimated increase in expenditures attributable to the pharmacy fee-for-service component. Trend rates for pharmaceutical services were established based on historical growth from fiscal year 2008 through fiscal year 2011, national pharmaceutical trends, and recent historical rebates percentages.

   The capitation rate increase from R2 to P1 (reflected in the state plan program change and (b)(3) inflation) is attributable to a mixture of increased utilization and higher unit costs. Contractual requirements for the PIHPs require improved beneficiary access to services, and thus utilization of services will increase. Additionally, high enrollment growth has been experienced in the adult TANF and DAB populations. Due to a higher proportion of adult enrollees, the composite morbidity for both populations has increased.

   The overall trend changes from P1 to P2 reflect the estimated combined increase in pharmacy costs and capitation rates. Trend estimates were developed based on estimated age/gender mix changes and historical cost increases observed in the covered services.

   In addition to these changes the state is implementing an additional incentive program to increase access and intensity (amount, scope and duration) of mental health service for children served by the Michigan Department of Human Services (MDHS) in the child welfare system.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   The state plan inflation trend rates for the Base Year (R2) to the first projection year (P1) reflect the estimated increase in expenditures attributable to fee-for-service pharmacy expenditures. Capitation rate changes from R2 to P1 are reflected as a programmatic adjustment. Since April 1, 2010, the State has been unable to determine actual pharmacy rebates. At the direction of CMS, estimated pharmacy rebate amounts have been included in R1 and R2. R2 to P1 trends specific to pharmacy costs are the following: 4.0% DAB,

6.0% TANF, and 8.0% MCHIP. The following table illustrates the state plan inflation trends included in Appendix D.5.

Trend by MEG State Plan Trend
MCHIP 1.24%
TANF 0.85%
DAB 0.37%
Waiver C 0.00%

For state plan costs in P2, trend rates for capitated services were established based on historical cost changes observed in encounter and financial cost report data from fiscal years 2008 through 2010. The trend rates reflect estimated age/gender mix changes in each MEG during the projection period. Trend rates for pharmaceutical services were established based on historical growth from fiscal year 2008 through the first half of fiscal year 2011 and national pharmaceutical trends. The actual estimated state plan inflation included in worksheet D.5. reflects the estimated cost mix between capitated and fee-for-service pharmacy costs.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

The principal factor contributing to to a higher annualized rate of change between P1 and P2 is the addition of ABA services through the §1915(i) authority. These services were not included in the time periods prior to P2, and the costs of these services will lead to an increase not related to historical trends.

Appendix D7 - Summary