Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June, 2012

v1.0

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Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program

Facesheet

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.

The **name of the waiver program** is Waiver for Children with Serious Emotional Disturbances (SEDW).
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
_**X**_ a request to amend an existing waiver, which modifies Section/Part **Section A/Part B of MI-17** (Changes are noted in **SMALL CAPS**)
___ a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Section B is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of **6 MONTHS**, beginning **04/01/2015** and ending 09/30/2015.

State Contact: The State contact person for this waiver is Jacqueline Coleman and can be reached by telephone at (517) 241-7172, or fax at (517) 241-5112, or e-mail at colemanj@michigan.gov. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

On **OCTOBER 30, 2014**, a Notice of Intent to submit a request to **AMEND** Michigan's §1915(b)(4) FFS Selective Contracting Waiver to operate concurrently with Michigan's §1915(c) Home and Community Based Services (HCBS) Waiver for Children with Serious Emotional Disturbances (SEDW) was sent to Tribal Chairs and Health Directors. To date, Michigan has not received any questions or comments from the Tribal Chairs and/or Health Directors regarding the request to **AMEND** this §1915(b)(4) Waiver.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

Michigan submitted a request for a §1915(b)(4) FFS Selective Contracting Waiver to operate concurrently with the §1915(c) Home and Community Based Services (HCBS) Waiver for Children with Serious Emotional Disturbances (SEDW), effective April 1, 2012. The §1915(b)(4) FFS Selective Contracting Waiver was requested to address Freedom of Choice concerns associated with Michigan's SEDW service delivery model.

The §1915(c) SEDW provides services that are additions to Medicaid State Plan coverage for children with serious emotional disturbances (SED) up to the child's 21st birthday. The waiver permits the State to provide an array of community based services to enable children who would otherwise require hospitalization in Michigan's State Psychiatric hospital for children (Hawthorn Center) to remain in their home and community.

Since its inception in October 2005, the Michigan Department of Community Health (MDCH) has operated the SEDW through contracts with local Community Mental Health Services Programs (CMHSPs) that expressed the desire - and demonstrated the capacity - to provide SEDW services. Oversight of the SEDW is provided by the MDCH, which is the single State Medicaid Agency. Two administrations within the MDCH - Behavioral Health and Developmental Disabilities Administration (BHDDA) and the Medical Services Administration (MSA) - have responsibility for operations and payments, respectively. Services are provided directly by CMHSPs and their contracted providers. Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and his/her family and friends, and other professional

members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in a Plan of Services (IPOS).

Since the initial §1915(c) SEDW (FY06 through FY08), there have been one 5-year renewal and several amendments – each of which accomplished one or more of the following: added new service areas and CMHSPs, revised eligibility criteria, increased Factor C (unduplicated count), added waiver services.

The purpose of the §1915(b)(4) renewal for FY14 and FY15 was to continue to operate concurrently with the §1915(c) SEDW, thereby maintaining successful service relationships. A renewal application for the §1915(c) SEDW was simultaneously submitted for FY14 through FY18. The §1915(c) SEDW renewal application added one additional contracted provider (West Michigan Community Mental Health System) for an additional service area (Oceana County). The renewal §1915(c) SEDW application also reduced the requested Factor C (unduplicated count) from 1243 (approved for FY13) to 804 for FY14 and 969 for FY15. The requested unduplicated count exceeded maintenance-of-effort requirements and was more realistic considering unmet need in the identified service area.

THE SOLE PURPOSE OF THIS AMENDMENT IS TO REVISE THE DESCRIPTION OF *"MEDICAID PAYMENT FOR SERVICES"* IN SECTION A (WAIVER PROGRAM DESCRIPTION), PART B (DELIVERY SYSTEMS), TO REFLECT A REQUEST TO AMEND APPENDIX I (FINANCIAL ACCOUNTABILITY) OF THE CONCURRENT §1915(C) HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES (SEDW) TO ADD A COST ADJUSTOR PAYMENT TO THE SEDW FOR DATES OF SERVICE ON/AFTER APRIL 1, 2015.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

CMS-Approved Waiver Services: Respite; Child Therapeutic Foster Care; Community Living Supports; Community Transition; Family Home Care Training; Family Support and Training; Therapeutic Activities; Therapeutic Overnight Camping; Wraparound; Home Care Training – Non Family.

State Plan Services: Psychiatric Diagnostic Interview Examination; Interactive Psychiatric Diagnostic Interview; Psychotherapy; Interactive Psychotherapy; Family Psychotherapy (with and without Patient); Group Psychotherapy; Medication Management; Speech/Hearing Evaluation; Speech/Hearing Therapy, Individual and Group; Psychological testing; Neurobehavioral Status Exam; Neuropsychological Testing; Therapeutic Injections; Occupational Therapy - Evaluation and Re-evaluation; Sensory Integrative Techniques; Medical Nutrition Therapy; Medical Nutrition Therapy Reassessment; Alcohol and/or Drug Assessment; Alcohol and/or Drug Services; Mental Health Assessment (by non- physician); Community Psychiatric Supportive Treatment; Crisis intervention service; Monitoring or changing drug prescriptions; Non-emergency Transportation; Nutritional Counseling, Dietitian Visit; Nursing Assessment/Evaluation.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a._X_ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._X_ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   _X_ different than stipulated in the State Plan (please describe)

   The reimbursement methodology is as described in Michigan's current §1915(c) Home and Community Based Services (HCBS) Waiver for Children with Serious Emotional Disturbances and in the renewal application for this waiver, excerpted here.

   Administrative Costs:
   The structure of each CMHSP varies in relationship to its responsibilities. Each CMHSP may perform any number of the following functions: 1) direct service provider, 2) administer one or more waiver programs, or 3) operate as a Pre-paid Inpatient Health Plan (PIHP). The logic of the PIHP/CMHSP Administrative Cost Report enables CMHSPs to separately identify administrative costs associated with these various responsibilities.

   The MDCH will reimburse CMHSPs the Federal share of actual CMHSP administrative expenditures attributed to the SEDW, as reported on a financial report certified as accurate by the CMHSP and submitted to the MDCH, the MDCH/CMHSP cost settlement process and the CMHSP audited financial reports. The amount reimbursed will be determined in compliance with A-87 principles.

Medicaid Payment for Services:

A MEDICAID INTERIM PAYMENT FOR EACH BILLABLE SED WAIVER AND MENTAL HEALTH STATE PLAN SERVICE - IN THE FORM OF A MEDICAID INTERIM FEE SCREEN - IS ESTABLISHED BY THE STATE MEDICAID AGENCY. MEDICAID INTERIM FEE SCREENS ARE PUBLISHED ON THE MEDICAID WEB SITE AND AVAILABLE TO PROVIDERS, WAIVER PARTICIPANTS AND THE GENERAL PUBLIC. INTERIM FEE SCREENS ARE BASED ON A LEGISLATIVELY-AUTHORIZED FORMULA APPLIED TO THE RELATIVE VALUE UNIT (RVU) FOR THE BILLED HCPCS CODE. FOR THOSE SERVICES FOR WHICH THERE IS NO RVU, THE RATE IS INITIALLY SET BASED ON DOCUMENTATION OF HISTORICAL CHARGES FOR THE SERVICE, ACROSS PARTICIPATING PROVIDERS. FEE SCREENS ARE REVISED AS DIRECTED BY LEGISLATIVE ACTION IN THE FORM OF REVISION OF THE FORMULA APPLIED TO THE RVU OR IN THE FORM OF ACROSS-THE-BOARD INCREASES OR DECREASES IN PROVIDERS' FEE-SCREENS. EFFECTIVE JANUARY 2015 THE STATE WILL BE USING THE MOST CURRENT RVU VALUE, UPDATING ON A YEARLY BASIS. THE CURRENT LEGISLATIVELY-AUTHORIZED CONVERSION FACTOR IS 21.53.

SERVICE CLAIMS ARE SUBMITTED TO MDCH THROUGH CHAMPS AND PAID UNIFORMLY AT THE ESTABLISHED MEDICAID FEE SCREEN OR BILLED CHARGE, WHICHEVER IS LESS. ONCE A YEAR, A FINAL FEE SCREEN IS DETERMINED, AS REFERENCED BELOW. IF A PROVIDER HAS CHARGES IN EXCESS OF THE INTERIM FEE SCREEN PAYMENTS, AN ADJUSTOR PAYMENT IS MADE AT THE END OF THE YEAR TO BRING THE INTERIM PAYMENTS UP TO THE FINAL FEE SCREEN, OR THE BILLED CHARGE, WHICHEVER IS LESS.

FINAL FEE SCREEN METHODOLOGY:

THE FINAL FEE SCREEN IS THE YEAR-END MAXIMUM AMOUNT PAYABLE FOR EACH SERVICE, DETERMINED VIA THE METHODOLOGY DETAILED IN THE REQUEST TO AMEND THE CONCURRENT §1915(C) SEDW.

THE NON-FEDERAL SHARE OF THE INTERIM PAYMENTS IS EITHER PAID WITH LOCAL GENERAL FUND OR OTHER LOCAL FUNDS FOR ONE GROUP OF SEDW CONSUMERS OR WITH AN MDCH STATE APPROPRIATION FOR ANOTHER GROUP OF SEDW CONSUMERS. THE NON-FEDERAL SHARE OF THE ADJUSTOR PAYMENT IS GENERAL FUND FROM THE MDCH STATE APPROPRIATION, ALLOCATED TO THE CMHSPS.

WITHIN MDCH, MICHIGAN'S SINGLE STATE MEDICAID AGENCY, THE MEDICAL SERVICES ADMINISTRATION (MSA) ESTABLISHES THE INTERIM FEE SCREENS (I.E., SERVICE PAYMENT RATES); THE BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION (BHDDA) IN COLLABORATION WITH MSA IMPLEMENTS THE METHODOLOGY THAT RESULTS IN THE FINAL FEE SCREENS. OVERSIGHT OF THE FINAL FEE SCREEN (RATE) DETERMINATION METHODOLOGY IS PROVIDED BY THE STAFF OF MSA AND BHDDA. BOTH THE INTERIM AND FINAL FEE SCREENS ARE REVIEWED BY THE BUDGET, ACCOUNTING AND AUDIT OFFICES WITHIN MDCH.

Flow of Billings:

Claims for services provided to SEDW participants, whether provided by a CMHSP or a qualified provider contracted by the CMHSP are billed directly by the CMHSP to the MDCH in accordance with policies and procedures published in the "Billing and Reimbursement for Professionals" section of the Michigan Medicaid Provider Manual. The CMHSP may also choose to use a billing agent. The MDCH issues payments directly

to the CMHSP. All payments are made at the lesser of the charge for the service or the Medicaid fee screen.

2. **Procurement**. The State will select the contractor in the following manner:

___ **Competitive** procurement
___ **Open** cooperative procurement
___ **Sole source** procurement
_X_ **Other** (please describe)

Selected contractors are certified by the MDCH as a CMHSP-under the authority of Act No. 80 of the Public Acts of 1905, as amended. CMHSPs are enrolled with the MDCH as a Specialty Provider for the SEDW. The certification process and standards are detailed in Sub-Part 7 and 8 of the aforementioned Public Act.

(1) As a condition of state funding, a single overall certification is required for each CMSHP.

(2) The certification process shall include a review of agencies or organizations that are under contract to provide mental health services on behalf of the mental health services program.

(3) The governing body of a CMHSP shall request certification by submitting a completed application to the MDCH.

After the MDCH's acceptance of a complete application, a determination is done to see whether or not the applicant meets the certification standards. The certification process may include conducting an on-site review. Failure of the CMHSP to comply with the requirements of the certification process shall be grounds for the department to deny, suspend, revoke, or refuse to renew a program's certification.

The MDCH shall assess compliance with the following certification standards by determining the degree to which all of the following provisions apply:

(a) The organization has established processes, policies, and procedures necessary to achieve the required result.

(b) The established processes, policies, and procedures are properly implemented.

(c) The expected result of the processes, policies, and procedures is being achieved.

Certification standards address all of the following areas: governance; mission statement; community education; improvement of program quality; personnel and resource management; physical/therapeutic environment; fiscal management;

consumer information, education and rights; eligibility and initial screening; waiting lists alternative services; array of services; medication-control; and individual plan of service.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_X_ Beneficiaries will be limited to a single provider in their service area.
___ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The approved §1915(c) SEDW is limited to the following thirty-six counties, served by 24 CMHSPs: Allegan, Bay, Arenac, Berrien, Clare, Gladwin, Isabella, Mecosta, Midland, Osceola, Muskegon, Wayne, Clinton, Eaton, Ingham, Kalamazoo, Genesee, Gratiot, Jackson, Hillsdale, Livingston, Macomb, Kent, Newaygo, Grand Traverse, Leelanau, Roscommon, Wexford, Oakland, Marquette, Saginaw, St Clair, Calhoun, Van Buren, Washtenaw and Cass. The request to renew the §1915(c) SEDW adds one CMHSP for an additional county (Oceana). Participants are limited to the CMHSP that serves their county of residence.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Waiver service providers are held to the same standards for reimbursement, quality and utilization as other providers of Medicaid State Plan services, and the standards are consistent with access, quality and efficient provision of covered care and services.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

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

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
___ Blind/Disabled Adults and Related Populations
___ Blind/Disabled Children and Related Populations
___ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children
_X_ Other - participants enrolled in the §1915(c) SEDW

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
___ Other (Please define):

This note is added for clarity: Within the group of beneficiaries enrolled in the section 1915(c) Waiver for Children with Serious Emotional Disturbances, there are no excluded populations.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

   The MDCH uses the performance measures listed in its §1915(c) SEDW as a method to measure the timeliness of a Medicaid beneficiary access to the services covered under the selective contracting program.

   The contract between the MDCH and PIHPs/CMHSPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek or request services of a PIHP/CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders. There are three access standards that track how quickly a newly referred person can access the system. The standards are:

   1. Receive a pre-admission screening for Psychiatric inpatient care for whom the disposition was completed in 3 hours.

2. Receive a face to face meeting with a professional for assessment within 14 calendar day of a non-emergency request for services.

3. Start at least one ongoing service within 14 calendar days of a non-emergent assessment with a professional. Michigan's Mission Based Performance Indicator System provides data on the performance of CMHSPs for these and other selected indicators.

Children with Medicaid are not placed on a waiting list for Medicaid State Plan services and the PIHP/CMHSP must provide mental health services and supports appropriate to need. The SEDW offers necessary services and supports beyond what is available under the Medicaid State Plan to children who meet criteria for hospitalization in a State psychiatric hospital for children. If the PIHP/CMHSP determines that a child remains at risk and meets criteria for State psychiatric hospitalization for children, the CMHSP may complete and submit an application for the SEDW. The eligibility and access process for the SEDW is fully described in the concurrent 1915(c) waiver renewal application.

The comprehensive biennial site review described in the section 1915(c) application is an essential vehicle for ensuring that Michigan's home and community-based waivers are operated in a manner that meets the federal assurances and sub-assurances. The clinical record review and review of billed services are essential vehicles for assessing timely access to services and participants' satisfaction with services.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion

If deficiencies are identified during the site reviews, CMHSPs must submit a Plan of Correction to the MDCH within 30 calendar days of receiving the MDCH's Summary Report, and must indicate the steps taken to remediate the deficiency. In addition, participants have the right to local dispute resolution and to Medicaid Administrative Hearings if they are dissatisfied with services or with access to services.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

   When CMS recommended Michigan apply for a section 1915(b)(4) fee-for-service selective contracting waiver to operate concurrently with the §1915(c) Children's Waiver Program, they also required an amendment to the approved §1915(c) waiver for Children with Serious Emotional Disturbances to address compliance with section 1902(a)(23)(A) of the Social Security Act, and required submission of a concurrent §1915(b)(4) waiver. The §1915(b)(4) waiver preserved Michigan's established service delivery mechanism for the SEDW. Per concurrence of CMS when the initial §1915(b)(4) was submitted, no independent assessment was required because the establishment of the §1915(b)(4) waiver would not impact the manner in which the §1915(c) waiver had operated since its inception.

   As noted above, there is no change in access and eligibility as detailed in the approved §1915(c) waiver, or in timely access to needed services and to qualified providers. The contract between the MDCH and PIHPs/CMHSPs establishes standards for access to mental health services. These standards provide the framework to address all populations that may seek out or request services of a PIHP/CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorders.

   Each CMHSP's "catchment area" is comprised of one or more counties that may be approved for participation in the SEDW. The CMHSP is responsible to provide services to consumers enrolled in the SEDW who reside in the approved counties - either through its resources or through an agreement with the "county of financial responsibility" – i.e., the CMHSP serving the county that's responsible for the child's foster care placement or court ward ship. Section 6.4 – Provider Network Services – of the contract between the MDCH and CMHSPs specifies that the CMHSP is "…responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations…" of the contract. This means, among other things, that the CMHSP must:

   - Provide the MDCH with a complete listing and description of the provider network available to individuals living in the service area;
   - Notify the MDCH of any changes to the composition of the provider network organizations;
   - Have procedures to address changes in its network that negatively affect access to care;
   - Assure that the provider network responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the service area;

- Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility; and
- Assure that network providers do not segregate the CMHSP's recipients in any way from other people receiving their services.

CMHSPs are responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of the MDCH contract. To do so, the CMHSP may sub-contract for the provision of any of the services specified in the contract. So although the CMHSP is the only selective contracting program, choice amongst qualified direct service providers is assured in various ways. These include: choice among providers contracting with the CMHSPs; choice of CMHSP employees who are direct service providers; and adding providers upon consumer request.

In order to provide an appropriate, adequate array of service providers, each CMHSP establishes a procurement schedule and process for contracting with direct service providers. The CMHSP also routinely expands its provider panel to meet identified needs of its consumer base - including children enrolled in the SEDW. In addition, if a SEDW consumer or his/her family identifies a qualified direct service provider who is not part of the CMHSP's provider network, the CMHSP will contact the provider to see if he/she is willing to contract with the CMHSP to provide services to the consumer.

The proxy for the CMHSP having “adequate capacity” of qualified providers is:

1) services are provided as needed and planned;

2) participants / families express satisfaction with direct service providers.

The Site Review process includes reviewing the Individual Plan of Service (IPOS) for each consumer randomly selected for the on-site review. Each IPOS is compared with assessments underpinning the IPOS, with the corresponding budget and with services billed to Medicaid for the specified time frame. One purpose of this aspect of the Site Review is to determine if services are provided in type, amount and duration as needed and as identified in the IPOS. If services were not provided as needed and planned, the review team looks for explanation as to why not. If the reason was access to, or availability of, qualified direct service providers, the review team looks for documentation of the steps taken by the CMHSP to address the problem. If the problem has not been resolved at the time of the site review, the CMHSP must address the issue in its Plan of Correction (POC). Another aspect of the site review is to ascertain consumer and family satisfaction with services. If the consumer or family expresses dissatisfaction with the availability of or access to

qualified direct service providers, the review team looks for documentation as to what strategies the CMHSP has implemented to address the consumer's / family's concerns.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

   If deficiencies are identified during the site reviews, CMHSPs must submit a Plan of Correction to the MDCH within 30 calendar days of receiving the MDCH's Summary Report and must indicate the steps taken to remediate the deficiency. The MDCH follows-up with the CMHSP within 90 calendar days of approving the CMHSP's Plan of Correction to assure it has been implemented.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

   The "utilization standard" is that participants receive medically necessary services in the amount, scope and duration identified in their IPOS. As noted above, the Site Review process includes reviewing the Individual Plan of Service (IPOS) for each consumer randomly selected for the on-site review. Each IPOS is compared with assessments underpinning the IPOS, with the corresponding budget and with services billed to Medicaid for the specified time frame. One purpose of this aspect of the Site Review is to determine if services are provided in type, amount and duration as needed and as identified in the IPOS. If services were not provided as needed and planned, the review team looks for explanation as to why not. If the reason was access to, or availability of, qualified direct service providers, the review team looks for documentation of the steps taken by the CMHSP to address the problem. If the problem has not been resolved at the time of the site review, the CMHSP must address the issue in its Plan of Correction (POC). Another aspect of the site review is to ascertain consumer and family satisfaction with services. If the consumer or family expresses dissatisfaction with the availability of or access to qualified direct service providers, the review team looks for documentation as to what strategies the CMHSP has implemented to address the consumer's / family's concerns.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   If deficiencies are identified during the site reviews, CMHSPs must submit a Plan of Correction to the MDCH within 30 calendar days of receiving the MDCH's Summary Report and must indicate the steps taken to remediate the deficiency. The MDCH follows-up with the CMHSP within 90 calendar days of approving the CMHSP's Plan of Correction to assure it has been implemented. In addition, participants have the right to local dispute resolution and to Medicaid Administrative Hearings if they are dissatisfied with services or with access to services.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

         Since this §1915(b)(4) waiver operates concurrently with a §1915(c) waiver, evidence of monitoring is submitted as part of the annual CMS 372 Report; specifically as documentation of the CMS-approved performance measures.

      ii. Take(s) corrective action if there is a failure to comply.

         The process for monitoring, including corrective action, is described in #2, below.

2. Describe the State's contract monitoring process specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

         Michigan's Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the §1915(c) waiver with which this §1915(b)(4) waiver operates concurrently. The

PIHPs/CMHSPs adhere to the same standards of care for each individual served and each PIHP/CMHSP meets the standards for certification as specified in the Michigan's Mental Health Code and Michigan Medicaid Provider Manual. The MDCH QMP staff is responsible for implementing the QMP at all PIHPs (comprised of all CMHSPs). A qualified site review team conducts comprehensive biennial site reviews to ensure that Michigan's §1915(c) waivers are operated in a manner that meets the federal assurances and sub-assurances. This site visit strategy covers all participants served by Michigan's Section 1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver participants.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per the MDCH policy; review and verification that Behavior Treatment Plan Review Committees are operated per the MDCH policy; follow up on reported critical incidents regarding medication errors and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code.

The biennial site review is the data source for discovery and remediation for many of the performance measures. The MDCH staff complete a proportionate random sample at the 95% confidence level for the biennial review for each §1915(c) waiver. At the on-site review, clinical record reviews are completed to determine that the IPOS:

- Includes services and supports that align with and address all assessed needs
- Addresses health and safety risks
- Is developed in accordance with the MDCH policy and procedures, including utilizing person centered/family centered planning
- Is updated as needs change, and at least annually

Clinical record reviews are also completed to determine that participants are afforded choice between services and institutional care and between/among service providers and that services are provided as identified in the IPOS. The MDCH site review staff conducts consumer interviews with at least one child and family whose record is selected in the proportionate random sample at each PIHP. The site review staff use a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-

centered planning and satisfaction with services. Interviews may be conducted in the provider's office, over the telephone or at the child's home.

A report of findings from the on-site reviews with scores is disseminated to the CMHSP with requirement that a plan of correction be submitted to the MDCH in 30 calendar days. The MDCH follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 calendar days after the plan of correction is approved by the MDCH.

Results of the MDCH on-site reviews are shared with the MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council. Information is used by the MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. Results of the MDCH on-site reviews are shared with the MDCH Behavioral Health and Developmental Disabilities Administration and the Quality Improvement Council.

ii. Take(s) corrective action if there is a failure to comply.

A report of findings from the on-site reviews with scores is disseminated to the CMHSP with requirement that a plan of correction be submitted to the MDCH within 30 days. The plan of correction must identify the steps taken to remediate deficiencies identified during the site review. Within 90 calendar days of approving the CMHSP's plan of correction, the MDCH will follow-up to ensure the plan has been implemented.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

As previously noted, the existing §1915(b)(4) waiver did not impact the manner in which the §1915(c) waiver has operated since its inception. Per the Michigan's Mental Health Code, the CMHSP is responsible for development of an IPOS for all participants served by the CMHSP. The IPOS must be grounded in assessments and must identify all services to be provided to the consumer. Direct service / care providers must be employees of the CMHSP, on contract to the CMHSP, or employees of an agency under contract to the CMHSP. Therefore, by identifying the CMHSP as the selective contracting program, coordination of care is assured.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

The MDCH web site provides information about the SEDW and directs participants to their local CMHSP to access needed services – including but not limited to – the SEDW.

B. Individuals with Special Needs.

_X_ The State has special processes in place for persons with special needs (Please provide detail).

Each PIHP/CMHSP must have a customer services unit. It is the function of the customer services unit to be the front door of the PIHP/CMHSP and to convey an atmosphere that is welcoming, helpful, and informative. The customer services unit is part of the PIHP/CMHSP access system.

Access system services must be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. The PIHP/CMHSP must arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines must be toll-free and accommodate people with Limited English Proficiency (LEP) and other linguistic needs, as well as be accessible for individuals with hearing impairments and must accommodate persons with diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication and mobility challenges.

The special needs of all consumers are accommodated – whether the need is access to particular mental health specialists; special accommodation to address visual, hearing, mobility, communication, physical, behavioral or other challenges; geographic accessibility and transportation issues; etc. In addition, CMHSPs must not only assure equal *access* for people with diverse cultural backgrounds, language of choice, and/or limited English proficiency but services and supports provided by the CMHSP must demonstrate a commitment to linguistic and cultural competency to assure meaningful participation for all people in the service area. Similarly, an individual's special needs don't result in "differences in care planning", as the Michigan Mental Health Code requires that all individual plans of service (IPOS) are developed using a "person-centered planning" (PCP) process. And the principles inherent in the PCP process dictate that each consumer's special needs are accommodated in both the planning process and the IPOS. For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition

into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

   The SEDW – since its inception – has reimbursed CMHSPs on a fee-for-service basis; and CMHSPs have been the sole entity responsible for providing services to SEDW participants. Therefore there is no way to supply data comparing "…fee-for-service cost trends for comparable services experienced prior to introduction of the selective contracting waiver, outside the geographic region covered by the selective contracting waiver or in the commercial marketplace…"

   As in the initial §1915(b)(4) waiver request, Michigan's actual expenditures for the prospective years will not exceed projected expenditures for the prospective years; and actual expenditures for the prospective years for the concurrent §1915(c) waiver will continue to meet "cost-neutrality" requirements.

2. Project the waiver expenditures for the upcoming waiver period.

   Year 1 from: 10/01/2013 to 09/30/2014

   Trend rate from current expenditures (or historical figures): 1.35%

   Projected pre-waiver cost ___NA__
   Projected Waiver cost $10,519,505
   Difference: ___NA__

   Projected PMPM $1,846.87

   Year 2 from: 10/01/2014 to 09/30/2015

   Trend rate from current expenditures (or historical figures): 1.35%

   Projected pre-waiver cost ___NA__
   Projected Waiver cost $12,768,598
   Difference: ___NA__

   Projected PMPM $1,871.80

Year 3 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 4 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 5 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____