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

September 18, 2013

Mr. Stephen Fitton
State Medicaid 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 §1915(b) renewal waiver application for the Children's Waiver Program. This §1915(b) waiver runs concurrently with the §1915(c) Children's Waiver Program, CMS control number 4119.R05. The CMS has assigned the §1915(b) waiver renewal control number MI-16.R01. The effective dates of this waiver are October 1, 2013 to September 30, 2015.

The CMS authorizes the state to utilize §1915(b)(4) and §1902 (a)(23) authorities within the Social Security Act to limit the providers of the §1915(c) waiver services and certain mental health state plan services to the Community Mental Health Service Programs. The CMS has based this decision on evidence the state submitted that demonstrates the information contained in the §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
Audrey Craft, MDCH
Debbie Dombrowski, DEHPG

Application for

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

June, 2012

v1.0

Table of Contents

Facesheet 3

Section A – Waiver Program Description 4

Part I: Program Overview
- Tribal Consultation 4
- Program Description 4
- Waiver Services 5
- A. Statutory Authority 5
- B. Delivery Systems 6
- C. Restriction of Freedom-of-Choice 8
- D. Populations Affected by Waiver 9

Part II: Access, Provider Capacity and Utilization Standards
- A. Timely Access Standards 10
- B. Provider Capacity Standards 11
- C. Utilization Standards 13

Part III: Quality
- A. Quality Standards and Contract Monitoring 14
- B. Coordination and Continuity-of-Care Standards 16

Part IV: Program Operations
- A. Beneficiary Information 17
- B. Individuals with Special Needs 18

Section B – Waiver Cost-Effectiveness and Efficiency 19

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 __Children's Waiver Program (CWP)_____.
(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.
___ a request to amend an existing waiver, which modifies Section/Part ____
_X_a renewal request MI-16

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

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

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years beginning 10/01/2013 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 April 29, 2013, a Notice of Intent to submit a request for a Renewal Application for Michigan's §1915(b)(4) FFS Selective Contracting Waiver to operate concurrently with Michigan's §1915(c) Home and Community Based Services (HCBS) Children's Waiver Program (CWP) 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 for 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) Children's Waiver Program (CWP), effective October 1, 2011. The §1915(b)(4) FFS Selective Contracting Waiver was requested to address Freedom of Choice concerns associated with Michigan's CWP service delivery model.

The §1915(c) CWP provides services that are additions to Medicaid State Plan coverage for children with developmental and intellectual disabilities up to the child's 18th birthday. The waiver permits the State to provide an array of community based services to enable children who meet "ICF/MR-DD" level-of-care to remain in their home and community.

Since its inception almost 20 years ago, the Michigan Department of Community Health (MDCH) has operated the CWP through contracts with local Community Mental Health Services Programs (CMHSPs). Oversight of the CWP 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.

The CMHSP is responsible for the coordination of the CWP services. The case manager, 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).

The purpose of this §1915(b)(4) renewal for FY14 and FY15 is to continue to operate concurrently with the §1915(c) CWP, thereby maintaining successful service relationships. The CMS-approved unduplicated count for the CWP for Waiver Years 4 and 5 (FY14 and FY15) is 469 - the same as for the current CWP §1915(b)(4).

Waiver Services:

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

CMS-approved Waiver Services: Respite Care (in- and out-of-home); Specialized Equipment and Supplies (miscellaneous DME, repair or non-routine service for DME, personal care items – ADL aids, miscellaneous therapeutic items & supplies – adaptive toys, specialized supply – allergy control supplies, and specialized medical equipment - environmental safety/control devices); Specialty Services (art, music, recreation, massage therapies); Community Living Supports (comprehensive support services); Non-emergency Transportation; Home Care Training (family and non-family); Financial Management Services; Environmental Accessibility Adaptations (home modifications); Vehicle Modifications

State Plan Services: Targeted Case Management; 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; Treatment of Swallowing Dysfunction; Evaluation of Auditory Rehabilitation Status; Auditory Rehabilitation, Pre- and Post-lingual Hearing Loss; Psychological testing; Assessment of Aphasia; Developmental Testing; Neurobehavioral Status Exam; Neuropsychological Testing; Therapeutic Injections; Physical Therapy - Evaluation and Re-evaluation; Occupational Therapy - Evaluation and Re-evaluation; Sensory Integrative Techniques; Therapeutic Exercises; Neuromuscular Reeducation; Medical Nutrition Therapy; Medical Nutrition Therapy Reassessment; Nutritional Counseling; Mental Health Assessment (by non- physician); Monitoring or changing drug prescriptions; Non-emergency Transportation; Nutritional Counseling, Nursing Assessment/Evaluation.; Aquatic Therapy; Gait Training Therapy; Massage Therapy; Manual Therapy; Therapeutic Activities (Group and Individual); Development of Cognitive Skills; Self-Care/ Home Management Training; Community/Work Reintegration Training; Wheelchair Management/Propulsion Training; Prosthetic Training; Behavioral Health – Short-term Residential; Medication Training and Support;); Comprehensive Multidisciplinary Evaluation; Physical or Manipulative Therapy Performed for Maintenance Rather than Restoration; Patient Education (Individual and Group); Crisis Intervention Mental Health Services

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.___ **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) CWP, excerpted here.

   1. Establishing Costs/Charges for Services:

   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 new 460 PIHP/CMHSP 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 CWP, 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 service - in the form of a Medicaid interim fee screen - is established by the MDCH and published on the MDCH website. The MDCH website can be viewed by providers, waiver participants and the general public. Service claims are submitted to the MDCH's claims processing system (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 described 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. CMS approved this methodology beginning in FY09, and the first adjustor payment was made in September 2009, based on FY08 expenditure data.

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 approved §1915(c) waiver renewal application.

The non-Federal share of the interim payments is paid with State appropriation to the MDCH. The non-Federal share of the adjustor payment is general fund from the MDCH State appropriation, allocated to the CMHSP.

Within the MDCH, 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 the MDCH.

Flow of Billings:
Claims for services provided to CWP enrollees, whether provided by a CMHSP, a qualified provider contracted by the CMHSP or under the Choice Voucher System, 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. That portion of the Manual also contains information about how claims are processed and how providers are notified of the MDCH actions. The CMHSP may also choose to use a billing agent. CHAMPS 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 CWP. 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) CWP is a statewide program. Each CMHSP has a designated service area comprised of one or more counties. 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) CWP

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 §1915(c) Children's Waiver Program, 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) CWP 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 CWP offers necessary services and supports beyond what is available under the Medicaid State Plan to children with developmental disabilities whose needs have placed them at risk for health, safety and/or out-of-home placement. Prior to considering a request for CWP services, the PIHP/CMHSP must review and utilize all available and appropriate Medicaid State Plan services for the child. If the PIHP/CMHSP determines that a child remains at risk and meets criteria for ICF/MR, a CWP pre-screen is completed and submitted to the MDCH.

A child identified as "at-risk" must have their urgent care needs met by the PIHP/CMHSP to ensure health, welfare, and safety while the child remains on the CWP Priority Weighing List. The PIHP/CMHSP must assess the child's needs and develop an Individual Plan of Service (IPOS) through the person centered / family driven / youth guided planning (PCP) process. A request for CWP services begins with a pre-screen completed by a Qualified Mental Retardation Professional (QMRP) and the child's parent(s). Determination of severity of need is based on program-specific criteria. The CWP Priority Weighing Criteria provides a consistent and objective basis on which to determine the priority status of children who may be eligible for the program.

Once a child is invited to apply for the CWP, the CMHSP has 30 days to submit an initial application to MDCH for review and confirmation of clinical eligibility for the CWP. Once eligibility is confirmed, services can begin as soon as qualified providers have been identified and trained, as long as an IPOS is developed and in the home within seven days of services beginning; and the CMHSP has 45 days to complete the formal application process.

CWP staff at the State level monitors CMHSPs' timeliness in completing the application and initiating services to eligible consumers. This is currently a manual tracking process, but has been incorporated into the design of the CWP web-based application to be implemented within the waiver cycle.

The comprehensive biennial site review described in the §1915(c) CWP 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 consumers' 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.

   Following submission of the CWP renewal application, and after extensive discussion with CMS and careful evaluation of alternatives by the MDCH, CMS recommended that Michigan apply for a §1915(b)(4) fee-for-service selective contracting waiver as it would address compliance with section 1902(a)(23)(A) of the Social Security Act while preserving Michigan's established service delivery mechanisms. 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 has operated for more than 20 years.

   As noted above, there is no change in access and eligibility as detailed in the approved §1915(c) CWP, 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, and the CMHSP is responsible to provide services to consumers enrolled in the CWP who reside in its catchment area. 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; engaging in Choice Voucher arrangements whereby the family can serve as the common law employer of direct care staff or can contract with professional 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 CWP. In addition, if a CWP 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; or - if the service is one that can be self-directed - to see if the provider is willing to provide services under Choice Voucher arrangements.

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

1) services are provided as needed and planned;

2) consumers / 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 consumers 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, consumers 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 the §1915(c) CWP, evidence of monitoring is submitted as part of the annual CMS 372 Report for the CWP; 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) 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 Mental Health Code and 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 consumers served by Michigan's §1915(c) waivers with rigorous standards for assuring the health and welfare of the waiver consumers.

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 calendar 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 for more than 20 years. Per the Michigan Mental Health Code, the CMHSP is responsible for development of an IPOS for all consumers 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, employees of an agency under contract to the CMHSP, or hired under Choice Voucher arrangements. 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 CWP and directs consumers to their local CMHSP to access needed services – including but not limited to – the CWP. As stated above, a request for CWP services begins with a pre-screen completed by a Qualified Mental Retardation Professional (QMRP) and the child's parent(s). Determination of severity of need is based on program-specific criteria. The CWP Priority Weighing Criteria provides a consistent and objective basis on which to determine the priority status of children who may be eligible for the program.

Once a child is invited to apply for the CWP, the CMHSP has 30 days to submit an initial application to the MDCH for review and confirmation of clinical eligibility for the CWP. Once eligibility is confirmed, services can begin as soon as qualified providers have been identified and trained, as long as an IPOS is developed and in the home within seven days of services beginning; and the CMHSP has 45 days to complete the formal application process.

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 CWP – since its inception – has reimbursed CMHSPs on a fee-for-service basis; and CMHSPs have been the sole entity responsible for providing services to CWP consumers. 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 $22,938,607
   Difference: ___NA__

   Projected PMPM $3,059.35

   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 $23,154,919
Difference: ___NA__

Projected PMPM $3,100.65

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: _____