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
Comp Plan	Comprehensive Health Care Program, CHCP	MCO;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Comprehensive Health Care Program

C. Type of Request. This is an:

☑ **Renewal request.**

☑ **This is the first time the State is using this waiver format to renew an existing waiver.**

The renewal modifies (Sect/Part):
Section A: Program Description/Part I: Program Overview - inclusion of dual eligibles as a voluntary instead of excluded population and Section D Cost Effectiveness – updates information on Medicare Part D and cost effectiveness.

The only significant change in Sections A through C is moving the dual Medicare and Medicaid eligible population from an excluded population to a voluntary population.

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0011

Amendment Number (if applicable): 7

Effective Date: (mm/dd/yy) 11/01/11

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.18.06.00
Waiver Number: MI.0011.R06.00

D. Effective Dates: This renewal is requested for a period of 4 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)

Proposed Effective Date: (mm/dd/yy)
11/01/11

Proposed End Date: 10/31/13
Calculated as "Proposed Effective Date" (above) plus two years minus one day.

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:

☐ **Comprehensive Health Care Program, CHCP**

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.
Notification on the intent to submit an amendment for CHCP was mailed to the Tribal Chairs & Health Directors and posted on the Michigan Department of Community Health (MDCH) website on May 18, 2011. Tribal populations are eligible for MCO enrollment on a voluntary basis. The quarterly Tribal Health Directors meeting offers Tribal chairs and the health directors an opportunity to be updated on the activities, operations, and changes of the Medicaid Managed Care Program.

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).
The implementation of Michigan's 1915 (b) Waiver Program, The Comprehensive Health Care Program, CHCP, was initiated in 1996 to institute "value purchasing" as the mechanism for addressing issues facing Michigan's Medicaid Program. The development and implementation of a competitively bid managed care program in 1997, 1998, 2000, 2004, and 2009 have resulted in the following accomplishments:
• Access to care is assured for enrolled beneficiaries;
• Accountability has been established and is in place through contracts with Medicaid Health Plans (MHPs);
• Costs are now predictable;
• Performance of MHPs is measured;
• Successful implementation of P4P (Pay for Performance) through annual performance bonus and auto-assignment algorithm program;
• Customer satisfaction is achieved; and
• Michigan's CHCP has been deemed successful by external auditing and oversight agencies.

Currently, Michigan Department of Community Health (MDCH) contracts with 14 Medicaid health plans (MHP), to provide a comprehensive set of health care services for over 1 million of the State's Medicaid beneficiaries. Over the last waiver periods, Michigan has focused on continuing to improve operations, reporting, and data assessment, rather than modify prior approved objectives. Michigan's CHCP program continues to operate key approved programs from the past waiver renewal period that enable Michigan to meet the objectives of accessibility to care, accountability, predictable costs, and measurable increases in performance. Some of these programs include:

• The CHCP continues to seek consultation from stakeholders who have an interest in the Medicaid program generally and managed care specifically. The MDCH continues to meet with the Medical Care Advisory Committee, the Mental Health Advisory Committee, and the Clinical Advisory Committee. At quarterly meetings of each of these committees, MDCH provides policy implementation information and obtains feedback and information from key stakeholders to facilitate quality policy decisions. The Advisory Committees are integral in assisting DCH develop strategies for collaboration among the various groups that serve the Medicaid population. DCH also disseminates information between formal meetings including briefings regarding the intended changes to be reflected in the waiver renewal.

• Michigan continues to operate the "rural exception" and Preferred Option Programs program based on the final BBA rules. These programs allow the state to mandate enrollment in counties with a single health plan. Under the rural exception, Michigan ensures that enrollees are afforded the opportunity to choose from at least two physicians and that enrollees may obtain services from a non-network provider under certain circumstances. Under the Preferred Option Program, beneficiaries are allowed to choose between fee-for-service and the preferred option plan. If the beneficiary does not make a choice, then s/he is automatically enrolled into the preferred option plan. Preferred Option enrollees are able to disenroll from the preferred option plan at any time. As a result of the successful 209 re-bid activities, the number of Preferred Option Counties has decreased from 10 to 4 over the most recent waiver period. Michigan seeks to continue the "rural exception" and Preferred Option Program with this waiver renewal. (See Medicaid Managed Care Contract, Sections 1.022(A)(4) Rural Area Exception and 1.022(A)(5) Preferred Option Program).

• Michigan has maintained and expanded the emphasis on pay for performance. Key components of this approach are the auto-assignment algorithm, monthly performance monitoring reports, and the performance bonus award program. Each of these initiatives involves tracking MHP's performance for key performance measures across time using HEDIS, CAHPS, encounter data and other sources. The auto-assignment algorithm is modified quarterly and allows Michigan to auto-assign beneficiaries into plans based on performance. Michigan also continues to prepare and distribute monthly Performance Monitoring Report. Over the past waiver period, Michigan increased the number of measures from 10 to 13 key performance measures adding 2 HEDIS well-child measures and pharmacy encounter data volume.

• The performance bonus award program utilizes each plan's objective measures across several categories to reward high performing health plans. Specifically, the performance bonus plan incorporates: 1) clinical and access scores as reported in the most current HEDIS results; 2) member satisfaction utilizing CAHPS scores; 3) legislative incentives/MDCH focus; and 4) accreditation status. In 2010, Michigan incorporated participation in Health Information Technology into the performance bonus award. For 2011, the performance bonus also included measures for e-prescribing and Person Centered Medical Home technology and participation.

• Effective 10/1/08, Michigan began mandatory enrollment of pregnant women into the MHPs. Prior to this time, newly Medicaid-eligible pregnant women represented a significant portion of the population not enrolled in a managed care program. HEDIS scores and other measures indicate that pregnant women have access to high quality, coordinated pre-natal and post-partum care through the MHPs.

• Effective 11/1/10, Michigan began mandatory enrollment of foster care children into the MHPs. Foster care children residing in detention facilities, child care institutions, or in out-of-state placements remain an excluded population. To ensure the success of this program, monitoring the transition of foster care children in the MHPs was incorporated into the annual compliance review process. MDCH has also added a new indicator to the HIPAA 834 enrollment file so that MHPs can identify foster children upon enrollment and determine if assessment for specialized services is required. Additionally, MDCH established a workgroup to specifically address the EPSDT needs of the foster care population. The workgroup developed a workflow document that was shared with the health plans and all foster care workers to ensure that foster care children have access to needed services. MDCH continues to evaluate MHPs performance with the EPSDT work flow and overall provision of services to foster care children as part of the annual compliance review.

• One of the major projects in the most two recent waiver periods is the design and development of a new Medicaid Management Information System (MMIS). The new system, Community Health Automated Medicaid Processing System (CHAMPS), went live on September 18, 2009. CHAMPS replaced the previous MMIS that had been in place for approximately 25 years. CHAMPS has improve the efficiency and effectiveness of capitation payments and recoupments, allowing MDCH to track expenditures through ad hoc reporting, and making network and PCP information more readily available. One of the key features is the automation of recoupments and payments based on changes in rates, newborn enrollment or death. CHAMPS also improved automation of newborn enrollment and provides direct access to enrollment and eligibility history. Michigan completed the CMS certification visit for CHAMPS on May 6, 2011.

• A key component of the CHAMPS system is the Customer Relationship Management (CRM) subsystem. CRM replaced the Beneficiary Provider Contact Tracking System (BPCT) when the CHAMPS system as a whole went live in September 2009. CRM allows Enrollment Services staff to do the enrollments and disenrollment tracking in a single application. The system affords users real-time access to view information directly from CHAMPS about an Individual, a Provider, Third Party Liability (TPL), Claims, and Eligibility and Enrollment. Staff is also able to view previous contacts with the Department regarding the same individual or provider at a glance. Service Requests for changes in enrollment are created based on a contact to the Department for various reasons. There are processes that automatically create Service Requests for certain situations but the majority of services requests are created based on a phone call, fax, e-mail or other form of contact with the MDCH or its Enrollment Broker, MI Enrolls. The information included in the Service Request gives the MDCH the ability to track when the contact was made, where the contact originated, and ultimately what was done to resolve the issue. In calendar year 2010, an average of 64,000 Service Requests were created each month. Finally, Medicaid Health Plans use the CRM to communicate with the Department in a secure environment. Requests for Newborn Enrollments are submitted via CRM as well as requests for Administrative Disenrollments for members that have moved from their service area, have other commercial insurance, are deceased, or other reasons cited in the contract for disenrollment.

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*
      ☐ **Comp Plan**
   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*
      ☐ **Comp Plan**
   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*
      ☐ **Comp Plan**
   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*
      ☐ **Comp Plan**

      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*
      ☑ **Comp Plan**
   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
☑ **Comp Plan**

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
☑ **Comp Plan**

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
☐ **Comp Plan**

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.

-- Specify Program Instance(s) applicable to this statute
☐ **Comp Plan**

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.)

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)

☐ **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 contractor is at-risk for inpatient hospital services as well as the following services:
o Outpatient hospital services
o Rural health clinic (RHC) services
o Federally qualified health clinic (FQHC) services
o Other laboratory and x-ray services
o Early periodic screening, diagnosis and treatment (EPSDT) services
o Family planning services
o Physician services
o Home Health services.

A complete list of services covered by the MHPs is provided in Section 1.022(E) of the Contract.

Section A: Program Description

Part I: Program Overview

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

1. **Assurances.**
   - [x] 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.

2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Comprehensive Health Care Program, CHCP.** *"*

- ☑ **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

Rural Exception (See below)

Preferred Option

The MDCH implemented a Preferred Option Program to allow automated enrollment in certain counties. In preferred option counties, only one health plan is able to accept enrollment in the county or only one health plan has capacity and approval for enrollment. Under the Preferred Option Program, beneficiaries are allowed to choose between fee-for-service and the preferred option plan. If the beneficiary does not make a choice, then s/he is automatically enrolled into the preferred option plan. The enrollee is able to opt out of the preferred option plan at any time. The Preferred Option Program is described in Section 1.022(A)(5) of the Contract.

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)):

The rural area exception is operated in the following counties in Michigan: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

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

○ **Beneficiaries will be limited to a single provider in their service area**

Please define service area.

○ **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:

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] **Comp Plan**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     - [ ] **Comp Plan**
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)
Alcona	MCO	CSM, HPM, MOL
Alger	MCO	UPH
Allegan	MCO	CSM, HPM, MOL, PRI, GLH
Alpena	MCO	CSM, HPM, MOL
Antrim	MCO	CSM, HPM, MOL
Arenac	MCO	HPM, MCL, MOL
Baraga	MCO	UPH
Barry	MCO	HPM
Bay	MCO	HPM, HPP, MCL, MOL
Benzie	MCO	HPM, MOL
Berrien	MCO	CSM, HPM, MOL, GLH
Branch	MCO	CSM, HPM, GLH
Calhoun	MCO	CSM, HPM, GLH
Cass	MCO	CSM, HPM, GLH
Charlevoix	MCO	CSM
Cheboygan	MCO	CSM
Chippewa	MCO	UPH
Clare	MCO	HPM, MCL, MOL
Clinton	MCO	HPM, MCL, PMD
Crawford	MCO	HPM, MOL
Delta	MCO	UPH
Dickinson	MCO	UPH
Eaton	MCO	HPM, MCL, PMD
Emmet	MCO	CSM
Genesee	MCO	CSM, HPM, HPP, MCL, MOL, THC
Gladwin	MCO	CSM, HPM, MCL, MOL

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Gogebic	MCO	UPH
Grand Traverse	MCO	CSM, HPM, MOL, PRI
Gratiot	MCO	HPM, MCL, MOL
Hillsdale	MCO	CSM, HPM, PRI, GLH
Houghton	MCO	UPH
Huron	MCO	HPM, MCL, MOL, GLH
Ingham	MCO	HPM, MCL, MOL, PMD
Ionia	MCO	HPM, MCL, MOL, PMD
Iosco	MCO	CSM, HPM, MCL, MOL
Iron	MCO	UPH
Isabella	MCO	HPM, MCL, MOL
Jackson	MCO	HPM, PRI, GLH
Kalamazoo	MCO	HPM, MOL
Kalkaska	MCO	HPM, MOL
Kent	MCO	CSM, HPM, MOL, PRI, GLH
Keweenaw	MCO	UPH
Lake	MCO	HPM, MOL
Lapeer	MCO	HPM, HPP, MCL, MOL
Leelanau	MCO	CSM, PRI
Lenawee	MCO	HPM, GLH
Livingston	MCO	BCD, HPM, MID, GLH
Luce	MCO	UPH
Mackinac	MCO	UPH
Macomb	MCO	HPM, MCL, MID, MOL, THC, GLH
Manistee	MCO	HPM, MOL, PRI
Marquette	MCO	UPH
Mason	MCO	CSM, HPM, MOL
Mecosta	MCO	CSM, HPM, MOL, PRI
Menominee	MCO	UPH
Midland	MCO	HPM, MCL, MOL
Missaukee	MCO	HPM, MOL
Monroe	MCO	CSM, HPM, MOL, GLH
Montcalm	MCO	HPM, MCL, MOL, PRI
Montmorency	MCO	CSM, HPM, MOL
Muskegon	MCO	CSM, HPM, MOL, PRI, GLH
Newaygo	MCO	CSM, HPM, MOL
Oakland	MCO	HPM, MCL, MID, MOL, OCH, THC, GLH
Oceana	MCO	HPM, MOL, GLH
Ogemaw	MCO	CSM, HPM, MCL, MOL
Ontonagon	MCO	UPH
Osceola	MCO	HPM, MOL, PRI

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Oscoda	MCO	HPM, MCL, MOL
Otsego	MCO	CSM, HPM, MOL
Ottawa	MCO	CSM, HPM, MOL, PRI, GLH
Presque Isle	MCO	CSM, HPM, MOL
Roscommon	MCO	HPM, MCL, MOL
Saginaw	MCO	HPM, HPP, MCL, MOL, GLH
Sanilac	MCO	HPM, MCL, MOL, GLH
Schoolcraft	MCO	UPH
Shiawassee	MCO	HPM, HPP, MCL, PMD
St. Clair	MCO	HPM, MCL, MID, GLH
St. Joseph	MCO	CSM, HPM, GLH
Tuscola	MCO	HPM, HPP, MCL, GLH
Van Buren	MCO	CSM, HPM, GLH
Washtenaw	MCO	BCD, HPM, MID, MOL
Wayne	MCO	BCD, HPM, MID, MOL, OCH, PRO, THC, GLH
Wexford	MCO	HPM, MOL

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:
Due to the limitation on number of characters, the MCO names in the previous table were abbreviated. The following table provide the key to the abbreviations:

BCD - BlueCaid of Michigan
CSM - CareSource Michigan
GLH - UnitedHealth Plan Great Lakes
HPM - Health Plan of Michigan, Inc.
HPP - HealthPlus Partners, Inc.
MCL - McLaren Health Plan
MID - Midwest Health Plan
MOL - Molina Healthcare of Michigan
OCH - OmniCare Health Plan, Inc.
PMD - PHP-MM Family Care
PRI - Priority Health Government Programs, Inc.
PRO - ProCare Health Plan, Inc.
THC - Total Health Care
UPP - Upper Peninsula Health Plan

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):

Foster care children are subject to mandatory enrollment except children placed in a residential setting (e.g. Court Treatment Facility, Mental Health Facility, or Detention Center), Child Care Institute, out-of-state foster home/facility, or in jail.

Individuals with dual Medicare and Medicaid eligibility will be a voluntary population for the Comprehensive Healthcare Program. Individuals enrolled in a Medicaid Health Plan (MHP) will have the opportunity to remain in the MHP after becoming Medicare eligible. The individuals will have the opportunity to call MI Enrolls to disenroll at any time with no lock in.

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.
- [x] **Other Insurance** --Medicaid beneficiaries who have other health insurance.
- [x] **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.
- [x] **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.
- [x] **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
  The Children's Special Health Services Program serves children who have qualifying conditions under CSHCS. The special needs are the focal point of services versus primary care. Under this program, the State prior authorizes children who meet the requirements of the program and have qualifying diagnoses.
- [x] **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- [ ] **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- [x] **Other** (Please define):
  Spenddown, childcare institutions, refugee assistance programs and repatriate assistance programs, .

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:
Other insurance is an excluded population only for those individuals with other managed care (HMO/PPO,etc).

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):

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:
   - [x] 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):

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.
   - [x] 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:
     Enrollees are provided with access to FQHCs either in the county service area and out-of-network if an FQHC does not exist in the service area, when requested. See Section 1.022(F)(4) of the contract.
   - [ ] 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):

5. **EPSDT Requirements.**
   - [x] 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):

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:

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:
- An enrollee can access emergency medical care and family planning services without prior authorization.

Under the CHCP Contract, Medicaid beneficiaries may also seek the following covered services without prior authorization:
- Immunization and communicable disease management from local Public Health Departments regardless of network affiliation
- Routine women's health specialists and pediatric services from network providers
- Child & Adolescent Health Centers regardless of network affiliation

8. Other.

☐ Other (Please describe)

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**

   - [x] 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:

   - [x] 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:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

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

   - [x] 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:

   - [x] 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:

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:

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:

MDCH identifies the persons who are aging-out of the CSHCS program on the "three-month report" which is sent to the Local Health Department (LHD) affiliated with the client's county of residence. The LHD identifies persons with Medicaid coverage and provides out-reach and works with the client/families to identify the medical providers with whom the client has an established and current relationship. LHDs assist the client/family in contacting MI Enrolls to determine with which MHPs their providers contract. Clients/families are also encouraged to review the documents provided to the LHDs that indicate which of the identified MHPs require a co-pay as these costs can be significant to persons with special needs who have higher utilization rates than the standard population. Upon the results of the information obtained from MI Enrolls, the client/family, with the assistance of the LHD as needed, identifies which MHP would be best for the person. Joint planning meetings including the client/family, LHD and designated MHP are encouraged.

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:

Per the MHP contract, the MHP is required to do the following for members identified by MDCH as persons with special health care needs: (a)Conduct an assessment in order to identify any special conditions of the enrollee that require ongoing case management services; (b) Allow direct access to specialists (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs; (c) For individuals determined to require case management services, maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the enrollee.

MHPs must
• Identify CSHCS transition-specific staff
• Be responsive to the special needs of enrollees who have had CSHCS coverage
• Provide additional and timely care planning for this population
-- When contacted prior to enrollment effective date, have initial plan in place by enrollment, with completed plan within 30 days of enrollment
-- When contacted or notified by MDCH of post-CSHCS enrollee, have initial plan in place within two weeks of enrollment, with completed plan within 30 days of enrollment

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:

The CHCP Contract requires HMOs to take into consideration the requirements of the Medicaid program and how to best serve the Medicaid Population enrolled in the CHCP.
The MCO should recognize that special needs will vary by individual and by county and region. Therefore, the MCO must have an underlying organizational capacity to address the special needs of their enrollees, such as responding to request for assignments of specialist as PCPs, assisting in coordinating with other support services, and generally responding and anticipating needs of enrollees with special needs.

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:

Under the CHCP Contract, the MCO must allow a specialist to perform as a PCP when the enrollee's medical condition warrants management by a physician specialist. The need for physician specialist should be determined on a case-by-case basis in consultation with the Enrollee.

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**

- [x] 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:

- [x] 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.
- [x] 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:
07/12/10 *(mm/dd/yy)*
- [x] 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	Health Services Advisory Group		1) Determine MCO compliance with Federal Medicaid managed care regulations and quality standards 2) Validation of measure-ment 3)	

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
			Validation of PIP	
PIHP				

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**

   ☑ 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:

   ☑ 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. ☐ 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:

      The MHPs must adhere to the following guidelines:
      •(a) May only provide factual information about the MHP's services and contracted providers
      •(b) If the beneficiary requests information about services, the MHP must inform the beneficiary that all MHPs are required, at a minimum, to provide the same services as the Medicaid FFS program
      •(c) May not make comparisons with other MHPs
      •(d) May not discuss enrollment, disenrollment, or Medicaid eligibility;
      Allowed Marketing Locations/Practices Directed at the General Population:
      • Newspaper articles
      • Newspaper advertisements
      • Magazine advertisements
      • Signs
      • Billboards
      • Pamphlets
      • Brochures
      • Radio advertisements
      • Television advertisements
      • Noncapitated plan sponsored events
      • Public transportation (i.e. buses, taxicabs)
      • Mailings to the general population
      • Individual Contractor Health Fair for enrollee members as described in Section 1.022(CC)(3)
      • Malls or commercial retail establishments
      • Community centers
      • Churches
   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:

With the approval of MDCH, MHPs are allowed to promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of the entire approved service area. Direct marketing to individual beneficiaries or enrollees is prohibited. The MHP may not provide inducements through which compensation, reward, or supplementary benefits or services are offered to beneficiaries to enroll or to remain enrolled with the MHP. MDCH will review and approve any form of marketing.

Health plan marketing is assessed as part of the CHCP's annual compliance review. The HMO Contract specifies that prior approval is necessary before any "permissible" marketing activity is undertaken and describes the prohibited marketing activities and locations.

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):

Prevalent Language is defined as Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's enrollees. Materials are translated into all Prevalent Languages.

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:

Prevalent Language is defined as Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's enrollees.

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:

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):

Prevalent Language is defined as Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's enrollees. Enrollee materials are translated into all Prevalent Languages.

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 5 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.

All enrollee services must address the need for culturally appropriate interventions. The enrollee handbook must describe how to obtain oral interpretation services and written information in prevalent languages and how to obtain written materials in alternative formats for enrollees with special needs.

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

Please describe:

Marketing materials must be available in languages appropriate to the beneficiaries being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the Americans with Disabilities Act.

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:

Marketing materials and provider information are available from the enrollment broker MI Enrolls upon request of a potential enrollee. Health fairs, ads, radio and television spots are also marketing alternatives that are reviewed by MDCH before presentation.

☐ 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
- [x] State contractor

Please specify:

MI ENROLLS

- [ ] 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:
Enrollment Counseling is provided by MICHIGAN ENROLLS through telephone access, face-to-face meetings and via information distributed in the mail. MICHIGAN ENROLLS holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. All counselors hired by Maximus, (dba MICHIGAN ENROLLS) receive initial training that addresses the special needs of the Medicaid population, such as referral to community mental health agencies and other local agencies that provide services for that population. They also receive desk references that provide the information that can be referenced after training is completed. The MICHIGAN ENROLLS maintains a dedicated TTY phone line for hearing impaired. The field staff is also provided with the same training as the call center staff. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in assuring such services are available within the MCO choices for new enrollees.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

- [x] 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:

- [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)(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:

MDCH staff, including staff in the CHCP Program, continue to provide frequent presentations for provider groups, health care coalition meetings, and consumer groups. The MDCH has also developed information packages regarding the Medicaid Program and Managed Care Program as part of the Healthcare at mihealth.org ----a web based interactive program that is linked to the MDCH website and is part of e-Michigan. A description of activities is included on the website www.training.mihealth.org.

The enrollment broker does most of the outreach, see Part IV (B), mechanisms to help enrollees and potential enrollee's understand managed care.

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: MI ENROLLS

Please list the functions that the contractor will perform:

☑ choice counseling

☑ enrollment

☑ other

Please describe:

Enrollment Counseling is provided by MICHIGAN ENROLLS through telephone access, face to face meetings and information distributed in the mail. MICHIGAN ENROLLS holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. The majority of enrollment contact is through the telephone.

All counselors hired by Maximus, (dba MICHIGAN ENROLLS) are given initial training that addresses the special needs of the Medicaid population. MICHIGAN ENROLLS also

has desk references that provide the reference information that can be utilized after training is completed. MICHIGAN ENROLLS maintains a dedicated TTY phone line for hearing impaired. The field staff is also provided with the same training as the call center staff. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in assuring such services are available within the MCO network for new enrollees.

☐ 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.):

The policy to enroll dually eligible Medicare and Medicaid individuals will be effective 11/01/11. Enrollment will be effective statewide for this population 12/01/11.

☑ 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 20 ◉ **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 automatic enrollment algorithm combines clinical performance factors, administrative factors, and PCP to member ratio. The clinical factors are based on annual HEDIS measures and blood lead rates. The HEDIS and CAHPS measures are rotated quarterly with measures compiling a different area of focus: (Q1) pediatric care, (Q2) women's care (Q3) living with illness, and (Q4), and access to care. Clinical factors are weighted by 42%, administrative factors are weighted by 30%, and the access to care factor is weighted at 28%.

Individuals with special health care needs are included as part of the normal auto-assignment algorithm process. However, as described in Part II.C (above), Michigan takes special efforts to ensure that these individuals choose a health plan are are not auto-assigned.

- [x] The State automatically enrolls beneficiaries.
  - [x] 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).
  - [x] 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:

    MDCH implements the preferred option program in the following counties: Barry, Charlevoix, Cheboygan and Emmet. The enrollee may enroll in a health plan or FFS through the State's enrollment broker. If the enrollee does not enroll, s/he is assigned automatically to the preferred option health plan. The enrollee may disenroll from the health plan to FFS at any time.
- [ ] The State provides **guaranteed eligibility** of months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- [x] 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:

  A beneficiary may request an exception to enrollment in the MHP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with any MCO available to the enrollee at the time of the enrollment. The Beneficiary would request this information within the first 30 days of enrollment from MDCH or MICHIGAN ENROLLS and complete and return an exemption form. MDCH will respond to the request and if granted, the beneficiary will be exempt for up to 12 months.
- [x] 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

- [x] 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.** [x] 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.
- [x] The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 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):

Reasons cited in a request for disenrollment for cause may include:
-Enrollee's current health plans does not, because of moral or religious objections, cover the service the enrollee seeks and the enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
-Lack of access to providers or necessary specialty services covered under the Contract. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor.
-Concerns with quality of care.
-The enrollee may request a disenrollment from his or her current MHP if the enrollee missed the opportunity to change health plans during the most recent open enrollment period due to a temporary loss of Medicaid eligibility

- [x] 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.
- [x] The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.
  - **i.** [x] MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

    Please describe the reasons for which enrollees can request reassignment

    The MCO may initiate special disenrollment requests to MDCH under the following general categories:
    - Fraud and abuse
    - Violent/life threatening situations involving physical acts of violence; physical or verbal threats of violence made against MCO providers, staff, or public at MCO locations or stalking situations;
    - Fraud/misrepresentation involving alterations or theft of prescriptions, misrepresentation of MCO membership, or unauthorized use of plan benefits; and
    - Non-compliant situations involving the failure to follow treatment plans, repeated use of non-MCO providers, etc.

    MCOs may initiate Administrative disenrollments for
    - Enrollment Error
    - Out of service area
    - Incarceration
    - Custodial placement in a long term care facility
  - **ii.** [x] The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
  - **iii.** [x] 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.** [x] 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:
C.2.d: Mandatory populations have a lock-in of 12 months after 90 days of enrollment. Vountary populations of Native Americans, dual eligibles, and migrant workers do not have a lock-in.

C.2.d.iv: For administrative disenrollment requested by the plan only, if the enrollee is unable to change plans, s/he is returned to FFS.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- [x] 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:

- [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)(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.
- [x] 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.

- [x] 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.

   - [x] 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:

   - [x] 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.
   - [x] 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**

   - [x] 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).
   - [x] The State's timeframe within which an enrollee must file a **grievance** is 90 days.

   c. **Special Needs**

   - [x] The State has special processes in place for persons with special needs.

     Please describe:

     The MHP must give all enrollees (including those with special health care needs) reasonable assistance completing forms, taking other procedural steps or other assistance necessary in filing grievances and appeals. The MHP must provide interpreter services and toll free numbers for enrollee questions and assistance.

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	[x] MCO	[ ] MCO	[ ] MCO	[ ] MCO	[x] MCO	[x] MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ 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
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	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ 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 ☐ 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
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

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
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 ☐ 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

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
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 ☐ 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 Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ 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 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.

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  - 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 ☐ 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	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ 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 ☐ 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	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ 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
Comp Plan	MCO;

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: Comprehensive Health Care Program, CHCP

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:
The Health plan must be accredited by one of the accrediting entities above. The health plan follows the accreditation application and review process as designated by the accrediting entity. Health plan provides evidence of accreditation to the State. State staff evaluates plan accreditation status at the time of annual site review and throughout the year as applicable.

Accreditation status information is published in the annual consumer guide made available to beneficiaries who are choosing a health plan.

☑ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☑ **Other**

Please describe:
URAC

c. ☑ **Consumer Self-Report data**

Activity Details:
According to MCO contract with the State, the health plan is required to submit an annual Adult Consumer Assessment of Healthcare Providers and Systems (CAHP®) survey conducted by a certified vendor. The State is contract with a certified CAHPS® vendor to conduct the child survey every other (odd) year beginning 2005.

The CAHPS® is used to assess beneficiary satisfaction with their healthcare experience. The CAHPS® results are utilized in the scoring methodology for the enrollee consumer guide and the Performance Bonus Award. The aggregate CAHPS® results provide important program information as part of the State's overall quality improvement strategy.

☑ **CAHPS**

Please identify which one(s):
The most current version of CAHPS Adult & Child

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:
The State generates reports from the Customer Relations Management system each quarter. These reports are used to evaluate enrollment and disenrollment trends, potential program integrity (fraud/abuse) issues, and coverage and authorizations. Additionally, the MHPs are required to submit reports on grievance and appeal activity within the plan semi-annually to the State.

The State also generates a Michigan Capacity report from the monthly provider file, to evaluate PCP/Specialist Capacity and access by plan and by county.

- ☐ **Denials of referral requests**
- ☑ **Disenrollment requests by enrollee**
  - ☑ **From plan**
  - ☐ **From PCP within plan**
- ☑ **Grievances and appeals data**
- ☑ **Other**

Please describe:
Provider Files

e. ☑ **Enrollee Hotlines**

Activity Details:
The State maintains a beneficiary MI Enrolls telephone line to address beneficiary inquiries regarding provider choice, enrollment/disenrollment, and other related questions and concerns.

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:
The state maintains the optional focused study as a component of the EQRO contract. DCH conducts specific focused reviews referenced as Focus Study in the State's compliance review (onsite) activity. DCH focuses on specific issues both clinical and non-clinical through this process.

g. ☑ **Geographic mapping**

Activity Details:
Michigan requires geographic mapping as part of the contract bidding requirements and for service area changes/expansions. This activity is monitored by the State during annual compliance review activity and intermittently for service area requests.

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

Activity Details:

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

Activity Details:
In 2007, Michigan participated in a Centers for Health Care Strategies (CHCS) project entitled Practice Size Exploratory Project (PSEP). MHPs serving Wayne County provided specific HEDIS data and provider demographics for analysis by our partners at the University of Michigan, Child Health Evaluation And Research (CHEAR). Data indicated disparities in quality care measures based on race. MHPs and individual practices were notified of results so that improvement efforts could be explored. While the project ended with CHCS, the Wayne County plans wanted to continue analysis of specific 2008 HEDIS measures. The State continued this project into 2009 with the assistance of the University of Michigan, collecting and analyzing practice level HEDIS quality of care measure data from the health plans that operate in Wayne County

Building on PSEP, Michigan is participating in the Reducing Disparities at the Practice Site

(RDPS) project, a three-year project that will involve working with a diverse stakeholder team, including Wayne County MHPs and selected provider practices (Michigan State University, University of Michigan, and Greater Detroit Alliance C). Project goal is to build the quality infrastructure and care management capacity of small practices that see a majority of Medicaid patients and serve a large volume of racial and ethnic minorities. Diabetes screening measures will be tracked over the course of the project and monitored for improvement in practice sites.

MDCH is collaborating with the Berrien County Health Department and three MHPs operating in Berrien County to address disparities in breast and cervical cancer screenings. This project is supported by an MDCH community grant and includes extensive outreach and follow-up to get African American women screened as necessary. Education and outreach efforts are being tracked, as well as increased screenings done in response to efforts.

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

Activity Details:
The network adequacy data provides evaluation of and information for provider capacity, provider selection and member choice.

Each month, the enrollment broker receives a file of each plan's provider network. With this file, the enrollment broker analyzes each county with the number of PCPs, hospitals, specialists and ancillary providers. The enrollment broker provides DCH with a capacity report indicating the network adequacy of each plan in each county. There are sanctions in place for those plans that do not report the provider network monthly. The department also uses this report to provide beneficiary choice and evaluate the ability of health plans to receive enrollment.

k. ☐ **Ombudsman**

Activity Details:

l. ☑ **On-Site Review**

Activity Details:
Michigan's reference for this activity is "compliance review". State staff conducts annual compliance reviews to evaluate health plan compliance with contract requirements for program integrity, information to beneficiary, grievance, timely access, PCP/Specialists capacity, coordination/continuity of care, coverage/authorization, provider selection, and quality of care. Compliance review reports summarize review findings and identify needed action and opportunities for improvement. The compliance review also obtains information on best practices of the health plans.

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

Activity Details:
Health Plans are required to conduct clinical and non-clinical PIPs. Generally, health plans select PIP topics specific to the populations within each plan. However, the State identifies topics selected for some County, regional or Statewide projects. Over this waiver period the State identified topics for PIP have been Disparity in Breast or Cervical Cancer Screening and Childhood Obesity for FY2011.

☑ **Clinical**

☑ **Non-clinical**

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

Activity Details:
The State and health plan are responsible for the performance measurement process. The State has established performance measures that are monitored on a regular basis. The scope of the performance monitoring measures includes quality of care, access to care, customer service, encounter data, and claims reporting and processing measures.

The State has also identified key HEDIS measures for tracking and trending. The State has a contracted vendor that evaluates the Health plan performance based on these measures annually and prepares a report of findings and recommendations to the Plans and the State.

These data provide information relative to grievances, timely access, and quality of care. DCH utilizes these data in setting quality strategy goals, performance standards, improvement plans and bonus awards.

The health plans are required to incorporate these findings into their annual Quality Assessment and Improvement/Work Plans, which is reviewed by the State annually.

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

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

Activity Details:
The State continues to conduct a periodic comparison of the number and types of Medicaid providers.

The States' enrollment contractor, Michigan Enrolls, conducts a monthly assessment of the number and types of providers in each health plan network to the State. This information is evaluated during the onsite activity annually, as necessary.

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

Activity Details:

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

Activity Details:

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

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

Activity Details:
The State requires health plans to monitor 24/7 PCP availability and minimum of 20 hours per week per location. State staff review plan processes at the time of the compliance review.

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

Activity Details:
The State and Health Plans conduct utilization reviews. As part of the annual compliance visit, the State assures that the Plan has a Utilization Managment Program that governs the Plan's utilitization review and decision-making.

t. [x] **Other**

Activity Details:
The State staff routinely conducts review of marketing, educational and member material to ensure contract compliance prior to distribution by the Health plan. The contract defines the criteria for appropriate marketing material.

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:

b. All health plans are accredited by one of the accrediting entities defined in the contract (NCQA (11) or URAC (3))
c. Health plans have conducted CAHPS surveys of their Medicaid adult populations each year during this waiver period. MDCH has conducted adult FFS surveys each year and FFS and managed care child surveys 2009 and 2011.
d. MDCH has generated beneficiary contact reports quarterly; sent plan specific results to the health plan and incorporated results into the performance monitoring report (PMR) quarterly Enrollee Complaint measure. Additionally, capacity was evaluated based on data from the enrollment broker, MI Enrolls. MI Enrolls produces a capacity report for the State's evaluation bi-monthly based on provider network data on electronic file submissions by the MHPs. The MHPs must submit a minimum of one complete and accurate provider network file to MI Enrolls each month but may submit provider files weekly. Currently, all contracted health plans meet capacity standards in their respective service areas.
e. The State continues to maintain a beneficiary MI Enrolls telephone line that has been incorporated into the overall systems update. It is now called the Customers Relation Management (CRM) system. The system affords users real-time access to view information directly from CHAMPS about an Individual, a Provider, and Eligibility and Enrollment. Staff is also able to view previous contacts with the Department regarding the same individual or provider at a glance. The information included in the Service Request gives the Department the ability to track when the contact was made and what was done to resolve the issue.
f. Focused studies were conducted each year through the compliance review process. Plan specific focused studies conducted during the waiver period can be found in the plan specific reports.
g. MDCH continues to implement the stringent capacity standard of 1:750 for ratio of PCP to members. As part of the annual compliance review, MHPs provide DCH the results of the geo-mapping access studies that demonstrate the PCP to

member ratio in the MHP's service area.
i. The PSEP project concluded with the state providing plan specific data to the Wayne County health plans to continue work at the practice level. The RDPS projects planned interventions for the grant period 2009-2011 include an electronic patient registry, adoption of evidence-based guidelines for diabetes care, and incorporation of team-based care into ongoing practice operations. The project concludes 9/30/2011 with 1 of 6 practices meeting NCQA level 1 patient-centered medical home (PCMH) status. All practices have received training in PCMH, practice transformation, and have been using registry software to track and outreach to their patients, including those with chronic diseases. The Berrien County project concluded in June 2009. Innovative, systems were developed by the Berrien County Health Department to track and reach out to women who were delinquent in receiving their breast and cervical cancer screenings.
As follow-up to the PSEP and RDPS projects, beginning 2011, the State will begin collecting rates for specific HEDIS measures from the health plans by race and ethnicity. In this initial year, the State will develop processes and methodologies for data collection; and overtime develop a Michigan rate and health equity index for each measure by race/ethnicity.
j. MDCH utilizes the capacity report to monitor network access each month and through the annual compliance visit. MHPs who did not meet the standard of 1 PCP for each 750 members in each county were required to submit additional documentation demonstrating how the plan ensured adequate access. MHPs utilized contiguous county providers and out of network providers as evidence of the plan's capacity to provide contractually required access to members. Once the additional documentation was reviewed, DCH did not identify any problems with network adequacy.
l. MDCH conducted compliance reviews each year of the waiver period. Plan specific corrective action plans were implemented according to the findings. The analysis and findings of this activity is reported in the External Quality Review (EQR) Technical report for MDCH which was submitted to CMS each year.
m. State designated PIPs were conducted and findings reported in the EQR Technical report for each year of the waiver. Staff reviewed other PIPs (clinical and non-clinical) conducted by the health plans as documented in the plans annual Quality Improvement program, work plan and evaluations.
n. Performance monitoring measures reports were to be sent to health plans monthly, however were delayed in 2009 of this waiver period due to production staff redirected priorities on the development, testing and implementation of the new MMIS system. The compliance review process had to be modified to accommodate the report with the time of compliance review. HEDIS measures were updated in accordance with NCQA updates, state focus, and related goals, objections and documents (Quality Strategy, consumer guide, performance bonus, and performance monitoring measures). Comparative analysis and results were provided each year by contracted vendor. All report sent to CMS.
o. MDCH monitors information from providers and enrollees regarding discrepancies in the MHP electronic provider network files. Plans must resolve any discrepancies within 30 days. Failure to do so leads to a "not met" score on this standard in the monthly performance monitoring report and the MHP must provide an action plan for re-gaining compliance.
r. 14 of 14 MHPs met the 24/7 PCP availability standard on the compliance review over this waiver period.
t. MHP education/promotion materials and activities are reviewed prior to distribution to members and during the compliance review.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
TANF	
Aged, Blind, and Disabled	
MCHIP	
Dual Eligibles	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2009	09/30/2010	10/01/2010	06/30/2011
Enrollment Projections for the Time Period*	10/01/2011	09/30/2012	10/01/2012	09/30/2013

**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	
Inpatient Hospital (excludes psych)	✓		✓	
Skilled Nursing Home - Restorative and Rehabilatative (45 day limit)	✓		✓	
Physician Services (includes 20 day outpatient psych)	✓		✓	
Outpatient Hospital (excludes psych)	✓		✓	
Prescription Drugs (excludes mental health drugs & HIV/AIDS drugs)	✓		✓	
Dental	✓			
Certified or Pediatric Nurse Practitioner	✓		✓	
Certified Nurse Anesthetist	✓		✓	
Oral Surgeons	✓		✓	
Nurse Widwives	✓		✓	
Podiatrist	✓		✓	
Chiropractors	✓		✓	
Optometrist	✓		✓	
Clinic Services	✓		✓	
Laboratory and Radiology (includes psych)	✓		✓	
Home Health - Intermittent or Part-time Nursing Services	✓		✓	
Home Health - Oxygen, DME, & Medical Supplies	✓		✓	
Prosthetics and Orthotics	✓		✓	
Vision Services and Eyeglasses	✓		✓	
Hearing Aids	✓		✓	
Speech and Hearing Services	✓		✓	
Sterilizations	✓		✓	
EPSDT Services	✓		✓	
Rural Health Clinic	✓		✓	
FQHC	✓		✓	
Tribal 638	✓		✓	
Respiratory Care	✓		✓	
Hospice	✓		✓	
Family Planning	✓		✓	
Skilled Nursing Home	✓			

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Mental Health Drugs & HIV/AIDS Drugs	✓		✓	

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: Oct 11, 2011

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:**
   Brian Keisling
c. **Telephone Number:**
   (517) 241-7181
d. **E-mail:**
   keislingb@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. ☐ The State provides additional services under 1915(b)(3) authority.
c. ☑ The State makes enhanced payments to contractors or providers.
d. ☐ 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 increase in Member Months over the years of the waiver renewal period reflects Michigan's economy at present. Michigan currently has one of the highest unemployment rates in the country. Jobs have been lost related to industry downsizing and in turn, related health care benefits have been cut or lost. Increasing numbers of individuals have turned to Medicaid for health care coverage.

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:
R1/R2 are both Federal fiscal year (FFY).

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:

a. ☑ **[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.

All services are included with the exception of dental services which are covered on a fee-for-service basis and under a separate 1915(b)(4) waiver in selected counties.

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
Inpatient Hospital (excludes psych)	☑	☐	☐	☐	☐	☐	☐
Skilled Nursing Home - Restorative and Rehabilatative (45 day limit)	☑	☐	☐	☐	☐	☐	☐
Physician Services (includes 20 day outpatient psych)	☑	☐	☐	☐	☐	☐	☐
Outpatient Hospital (excludes psych)	☑	☐	☐	☐	☐	☐	☐
Prescription Drugs (excludes mental health drugs & HIV/AIDS drugs)	☑	☐	☐	☐	☐	☐	☐
Dental	☐	☐	☐	☐	☐	☐	☐
Certified or Pediatric Nurse Practitioner	☑	☐	☐	☐	☐	☐	☐
Certified Nurse Anesthetist	☑	☐	☐	☐	☐	☐	☐
Oral Surgeons	☑	☐	☐	☐	☐	☐	☐
Nurse Widwives	☑	☐	☐	☐	☐	☐	☐
Podiatrist	☑	☐	☐	☐	☐	☐	☐
Chiropractors	☑	☐	☐	☐	☐	☐	☐
Optometrist	☑	☐	☐	☐	☐	☐	☐
Clinic Services	☑	☐	☐	☐	☐	☐	☐
Laboratory and Radiology	☑	☐	☐	☐	☐	☐	☐

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
(includes psych)							
Home Health - Intermittent or Part-time Nursing Services	☑	☐	☐	☐	☐	☐	☐
Home Health - Oxygen, DME, & Medical Supplies	☑	☐	☐	☐	☐	☐	☐
Prosthetics and Orthotics	☑	☐	☐	☐	☐	☐	☐
Vision Services and Eyeglasses	☑	☐	☐	☐	☐	☐	☐
Hearing Aids	☑	☐	☐	☐	☐	☐	☐
Speech and Hearing Services	☑	☐	☐	☐	☐	☐	☐
Sterilizations	☑	☐	☐	☐	☐	☐	☐
EPSDT Services	☑	☐	☐	☐	☐	☐	☐
Rural Health Clinic	☑	☐	☐	☐	☐	☐	☐
FQHC	☑	☐	☐	☐	☐	☐	☐
Tribal 638	☑	☑	☐	☐	☐	☐	☐
Respiratory Care	☑	☐	☐	☐	☐	☐	☐
Hospice	☑	☐	☐	☐	☐	☐	☐
Family Planning	☑	☐	☐	☐	☐	☐	☐
Skilled Nursing Home	☐	☐	☐	☐	☐	☐	☐
Mental Health Drugs & HIV/AIDS Drugs	☐	☑	☐	☐	☐	☐	☐

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:

The state identified annual waiver costs for individual Divisions and program functions within the agency responsible for administering the Medicaid program. Administrative expenditures associated with the waiver were then estimated based on a detailed review of these Divisions and functions. This review identified the following annual costs by category:

Waiver salaries: $7,691,383
DIT General Medicaid: $6,893,462
Health Plan Contracts: $4,908,947
Health Plan Contracts: $2,373,381
Total: $21,867,173

This year we rebuilt the process whereby we estimate the administrative costs associated with this waiver. Since we are pulling the information from different sources, we changed our classification categories. The new categories can be defined as follows:

Waiver Salaries: The amount of total Medicaid staff salaries which is dedicated to administering this waiver. For example, a very high percentage of the Managed Care Plan Division salaries would be allocated to the waiver since that division is responsible exclusively for managed care projects, of which this waiver is by far the biggest. On the other hand, the Actuarial Division's percentage allocation would be much lower (but still substantial) since the staff are involved in fee-for-service analysis as well as managed care analysis.

DIT General Medicaid: This refers to salaries and technology expenditures related to the MMIS and related Data Warehouse systems. We determined that 40% of claims and encounters are attributable to waiver members and we therefore allocated 40% of all DIT General Medicaid expenses to this waiver.

Health Plan Contracts 100% Waiver: This refers to agency contracts (or parts of contracts) with outside organizations that provide services exclusively to our waiver enrollees. The prime example here is our contract with Maximus, our broker for enrolling Medicaid clients into particular Medicaid Health Plans under this waiver. Although Maximus also does some non-Waiver work for the agency, the Maximus functions are clearly delineated such that a number of their functions are 100% allocable to the Waiver.

Health Plan Contracts – related to all TXIX: This refers to agency contracts (or parts of contracts) with outside organizations that provide services related to all Medicaid clients. Therefore, some portion of these contracts must be allocable to this waiver. Based on our analysis related to the "DIT General Medicaid" expenditures, we are allocating 40% of these "all TXIX" contracts to this waiver. Our contract with Milliman, USA, our consulting actuarial firm, is a prime example of this type of contract.

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.

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:

Dual eligibles are a voluntary population that have both the opt in and opt out privilege as if November 1, 2011 so there is no selection bias.

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.**

   i. The "traditional" bonus pool created by withholding .19% of the capitation payments and paid out to plans after the end of the year based on their HEDIS and other performance indicators, remains in place and will be administered as it has in the past. The criteria for the awards are communicated to the MCOs each year. These are the amounts noted in Tab D3, Column G.

   In addition, a new bonus payment is being added because of Michigan's participation as a pilot state in the CMS Primary Care Transformation project. Bonus payments outside the capitation rate but within the CMS approved rate range will be made to the health plans based on the number of MIPCT physicians and members they have. Some of these bonus payments will facilitate practice development and will be based strictly on MIPCT physician member counts and other payments will be based on performance as measured against criteria currently under development.

   Additionally, a bonus pool of $17.5 million has been created to incentivize health plans in the transformation of PCPs to provide coverage to Medicaid enrollees. Bonus payments will be awarded based on attributed lives in participating primary care practices.

   ii. For each contract year, performance bonus incentives are withheld from the capitation payments for the respective MCOs. The amount withheld for each year of the waiver period is 0.19% of the capitation payment.

   iii. The total payments will not exceed the Waiver Cost Projection because the incentives are included in the approved capitation payments. We have assumed the full bonus is paid under the waiver renewal. If performance criteria are not met, incentive payments are not awarded. Conversely, the award cannot exceed the amount from each capitation payment.

   Bonus payments for the Primary Care Transformation Project will not exceed the designated PMPM amount for each attributed life in each participating primary care practice.
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: _____
       Please document how that trend was calculated:
    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.

The trend rates used for the residual fee-for-service expenditures were determined based on historical experience. The state used FY 2008 through FY 2011-YTD experience along with actuarial judgment to develop reasonable FFS expenditure trends. The trends were developed on a linear basis with smoothing to eliminate large changes from quarter to quarter. The capitation payments trend of 3.5% for P2-P4 is based on historical HMO encounter claims cost trends observed in FY 2009-2010 data.

Residual fee-for-service expenditures refer to those services delivered to a person served under the waiver that are not included in the capitation payments. There are two types of residual fee-for-service expenditures for waiver clients. The first type would be services that are paid for while clients Medicaid and HMO enrollment are still in transition and some costs may have been paid fee-for-service. For example, in some cases clients eventually receive retroactive enrollment for a month but the HMO does not have control of the case for that month. The second type would be services that are carved out of the capitation payment and are not the HMOs' responsibility. The first type would include: physician services, hospital services, Home Health Agency services, durable medical equipment, and emergency transportation. The second type would include: specific pharmaceutical categories, vision, dental, hearing, school-based services, and home help/personal care. The capitation rate change as of October 1, 2011 is included in the program adjustment section.

We have further estimated 3.5% rate increases for the capitation payments for projection years P2 through P4. The future capitation rate increases are based upon an estimate of overall trends in the managed care market for covered services. The future rate increases reflect an estimate of the required rate increases to maintain actuarial soundness in the rates. We have not included the impact of the primary care fee schedule change required by ACA.

Finally, we have not included the impact of the enrollment or costs associated with the Medicaid expansion effective January 1, 2014.

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.**

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.

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

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.

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

iv. ☑ Changes in legislation.
Please list the changes.
0.9% increase for Capitation rate increase at October 1, 2011 in P1;
0.1% increase for the inclusion of Dual Eligibles in P1;
2.2% decrease due to the changes in tax policy on capitation payments in P1: and,
2.7% decrease due to the changes in the tax policy on capitation payments in P2

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
The change to base capitation rates is a 0.5% rate decrease for the TANF and MCHIP MEGs and a 2.9% increase to the ABAD MEG, an overall decrease. The current tax policy will be changed to eliminate a 5.98% Use Tax as of 3/31/12 and the inclusion of a 1% Claims tax on 1/1/12. This produces a 2.2% rate decrease for P1. The remainder of the tax policy change is reflected in P2 as a 2.7% decrease.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

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

3.50

Please describe:
The trend rate for administration is based on the Consumer Price Index and experience with the cost of in-house staff dedicated to managed care functions as well as contracts such as with the state's enrollment broker and pharmacy benefit manager.

D. ☐ Other
Please describe:

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

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

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:

Please provide documentation.

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

2. Please provide documentation.

B. State Plan Service trend

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

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
   The trend rate adjustment factors by MEG are by projection year:
   TANF: 0.4%, 3.5%, 3.5%, and 3.5%;
   MCHIP: 0.4%, 3.5%, 3.5%, and 3.5%;
   ABAD: 0.5%, 3.6%, 3.6%, and 3.6%;
   Dual Eligibles: 3.6%, 3.6%, 3.6% starting with P2
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
   The incentive trend rate adjustment factors by MEG are by projection year:
   TANF: 297.2%, 0.9%, 3.5%, and 3.5%;
   MCHIP: 445.4%, 0.9%, 3.5%, and 3.5%;
   Aged, Blind, and Disabled: 67.0%, 0.9%, 3.6%, and 3.6%;
   Dual Eligibles: 0.9%, 3.6%, 3.6% starting with P2
3. Explain any differences:
   The State Plan trend rates represent a blended trend rate of the capitation rates and the residual state plan services paid fee-for-service. The incentive is a function of the capitation rates. The incentive rates are 0.19% of the capitation rates. A bonus pool of $17.5 million has been created to incentivize health plans in the transformation of PCPs to provide coverage to Medicaid enrollees.

Section D: Cost-Effectiveness

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

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

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  - 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

Section D: Cost-Effectiveness

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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.

Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

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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.

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

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 increase in member months is attributable to the projected increase in Medicaid eligibles over the years of the waiver renewal period. The projected growth is based on enrollment trend data that reflects Michigan's current economy. Michigan currently has one of the highest unemployment rates in the country. Jobs have been lost related to industry downsizing and in turn, related health care benefits have been cut or lost. Increasing numbers of individuals have turned to Medicaid for health care coverage. These values do not reflect the Medicaid expansion under ACA.

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 rate of increase shown in Appendix D7 Column I primarily reflects the changes in capitation rates that have or will occur due to the establishment of actuarially sound capitation rates. Additionally, there areresidual services that have been included that are paid on a fee-for-service basis. These costs were also included in the waiver filing. The rate of growth projected for these services was estimated based on the historical regression trends for these services.
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 trend rates used for the residual fee-for-service expenditures were determined using historical experience. For the capitation rate component of the trend rate increase, we have estimated the increases in the capitation rates through FY 2015 to reflect the increase to maintain actuarially sound capitation rates.

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

Appendix D7 - Summary