5Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 29, 2009

Mr. Stephen Fitton, Acting Director
Medical Services Administration
Michigan Department of Community Health
Capitol Commons Center
P.O. Box 30479
Lansing, Michigan 48909

Dear Mr. Fitton:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Michigan's renewal application for the Comprehensive Health Services Program (Comp Plan) under CMS control number MI-11.R05. This waiver is authorized under §1915(b)(1), §1915(b)(2), and §1915(b)(4) of the Social Security Act (the Act), and grants Michigan waiver of §1902(a)(1) of the Act on statewideness, §1902(a)(10)(B) of the Act on comparability, and §1902(a)(23) of the Act on freedom of choice.

My decision is based on the evidence submitted to CMS demonstrating that the information contained in the State's renewal application is consistent with the purposes of the Medicaid program and will meet all the applicable statutory and regulatory requirements for operating a §1915(b) waiver program. The current waiver authority expires as of June 30, 2009. However, we have considered the State's May 13, 2009 request to change the waiver period to coincide with the State fiscal year, which runs from October through September, and all Managed Care Organization (MCO) contracts, cost accumulation and MCO rate setting occurs on a fiscal year basis. We agree with the State's position that the alignment of the waiver period with the State fiscal year will increase the administrative efficiency and improve both timeliness and completeness of all associated waiver reporting and renewal requirements. Therefore, we are approving this request by authorizing the authority granted by this letter to extend through September 30, 2011.

This approval is conditioned upon the State's acceptance of the following term and condition: Cost effectiveness is one of the requirements for maintaining a §1915(b) waiver. Correct reporting of waiver information will result in accurate determinations of cost effectiveness. Failure to demonstrate cost effectiveness may jeopardize renewal of a waiver. In most cases, the State will be required to submit to CMS an amendment to the waiver for any cost effectiveness projection changes on a prospective basis.

The CMS is requiring the State work with local CMS personnel to analyze and research the following: 1) the difference between what was reported on the CMS 64 and 21 reports, and what has been incorporated into AppendixD3, and. 2) the issue of why the MCHIP Medicaid Eligibility Group is not showing cost effectiveness for Retrospective period 1 and Retrospective period 2, as reported in Appendix D7.

Michigan must notify CMS in writing of its decision to accept or reject this conditional approval and term and condition within 15 days of the date of this letter. If we do not hear from the State by July 20, 2009, we will assume that Michigan will begin to phase out this waiver program and will follow up with the State on that process.

Michigan may request that this authority be renewed at the end of this waiver period, and should submit its request for the renewal no later than July 2, 2011. We wish you continued success in the operation of the Comprehensive Health Services Program. If you have any questions, please feel free to contact Pamela Carson, of my staff, at (312) 353-0108.

Sincerely,

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

cc: Cheryl Bupp, Michigan Department of Community Health
Nancy Bishop, Michigan Department of Community Health

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

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

The **name of the waiver program** is **The Comprehensive Health Care Program, CHCP**. (Please list each program name if the waiver authorizes more than one program.)

Type of request. This is an:

___ initial request for new waiver. All sections are filled.

___ amendment request for existing waiver, which modifies Section/Part ____

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

_**X**_ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

X The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is _ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_**X** assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

X __ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective **_July 1, 2009_** and ending **__June 30, 2011__**. (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)

State Contact: The State contact person for this waiver is **Cheryl Bupp** and can be reached by telephone at **(517) 241-7933** or fax at **(517) 241-8231**, or e-mail at buppc@michigan.gov (Please list for each program).

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.

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 the following issues:

- **Access to care**
- **Increased Medicaid expenditures**
- **Lack of accountability in the delivery service system**
- **Either lack of data or data indicating poor performance**
- **Customer services were cumbersome and inaccessible for many beneficiaries.**

The development and implementation of a competitively bid managed care program in 1997, 1998, 2000 and 2004 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.**
- **In an effort to improve coordination of care, the MDCH worked collaboratively with Michigan's Department of Human Services to amend the State's Medicaid application to obtain beneficiaries' consent and allow MHPs and other public health entities to share patient information.**
- **The State received approval from CMS to amend the Comprehensive Health Care Program on March 9, 2004, which allows DCH to increase health plan**

rates by 0.7%, in the aggregate, for outreach services to school-aged children. This waiver amendment requires all Medicaid health plans to contract with child and adolescent health centers to deliver outreach services, such as Medicaid applications, assistance and beneficiary education on EPSDT services, to school-aged children.

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 essentially the same programs from the past waiver renewal period. 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 DCH 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, DCH 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" program based on the final BBA rules. The "rural exception" program allows the state to limit a rural area resident to a single managed care entity and ensures that individuals are afforded the opportunity to choose from at least two physicians. In addition, individuals may obtain services from a non-network provider under certain circumstances. Michigan seeks to continue the "rural exception" with this waiver renewal. (See Attachment A, Medicaid Managed Care Contract, Section II-F, 4 pg. 27, Rural Exception Procedures).**

- **DCH continues to operate the Preferred Option Program to allow automated enrollment in more counties. Currently, Michigan is operating the Preferred Option Program in 10 counties. In preferred option counties, only one health plan has service area approval 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 disenroll from the preferred option plan at any time. (See Attachment A, Medicaid Managed Care Contract, II-F, 5, pg. 27).**

- **The State facilitates coordination between MHPs and LHDs by informing and identifying MHPs of those Persons with Special Health Care Needs (PSHCN) enrolled in their plan. DCH incorporated the State's definition of PSHCN in the contract and presented the State's expectations for addressing this population to the MHPs.**

- **In 2004, MDCH added a requirement to the MHP contract that the provider to member ratio be no less than 1:750. In the 2004 rebid of the Medicaid contracts, DCH required bidders to include the 1:750 ratio in their bid proposals to ensure complete and adequate provider networks for enrollees. Michigan continues to monitor the ratio as part of the on-site review process and incorporates MHP's performance on this ratio into the auto-assignment algorithm. DCH continued to require the 1:750 ratio as part of the 2009 rebid.**

- **The State continues to increase automation and efficiency through management information system processes to improve enrollment tracking of members in the MHPs. Three of the primary automated systems are birth record matching, death record matching and automated enrollment of newborns into the mother's MHP. The automation improves accuracy of capitation payments and improves the State's ability to recoup capitations paid to MHPs after the date of death.**

- **DCH has maintained and expanded the performance bonus award program. 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/DCH focus; and 4) accreditation status. A percentage of each month's capitation payment is withheld to form a bonus award pool. In 2008, DCH expanded the performance bonus program to award additional moneys for positive health behavior initiatives, advancements in health information technology/exchange, and participation in the specialty care access program. This addition to the bonus program is financed through the same withhold of capitation payments.**

- **Another element in Michigan's pay-for-performance approach is the auto-assignment algorithm. Performance measures are used to place Medicaid Health Plans into three groups based on the distribution of scores. The percentage of auto-assignments each MHP receives is based on group placement in each region. The State modified the algorithm to make it more dynamic and include a broader range of measures. DCH rotates HEDIS measures used on a quarterly basis. The quarterly measures focus on pediatric care (Q1), women's care (Q2), living with illness (Q3), and access to care (Q4). Additionally, the State implemented a group adjustment factor to reward MHPs with high quality and high enrollment. Specifically, if an MHP is above the midpoint in both relative regional enrollment and quality for the quarter, the MHP will be moved up one group placement in that region. The group adjustment factor allows Michigan to give more auto-assignments to MHPs who have achieved a relatively higher level of enrollment in a region only if the MHP has also demonstrated higher overall quality.**

- **MHPs are contractually obligated to achieve specified standards for ten key performance measures aimed at improving the quality and efficiency of health care services provided to the more than 950,000 Michigan residents enrolled in an MHP. Each month, DCH distributes a report that displays which MHPs meet or exceed the**

standards for each of the performance measures. The body of the report contains a cross-plan analysis of the most current data available for each performance measure. Performance monitoring measures includes yearly, quarterly, and monthly measures. The yearly HEDIS measures include the following: Childhood Immunizations, Prenatal Care, and Postpartum Care. Quarterly measures are developed from encounter data submitted by the MHPs and the State's contact tracking system and include the following: Well-Child Visits 15 Months, Well-Child Visits 3-6 Years, and Complaints. Monthly measures are based on encounter data as well as various reports and include the following: Blood Lead Testing, Encounter Data Reporting, Provider File Submission, and Claims Processing.

- **DCH continued to provide health plans with monthly historical medical and pharmacy data for newly enrolled members. Although this program is voluntary, nearly all the MHPs participate. The intent of this data sharing effort is to assist the plans in proactively addressing the needs of their new members. The data extract (set of predefined data elements) includes up to 12 months of encounter and fee-for-service claims/encounters. DCH is monitoring MHP's use of the data to ensure that the process is meeting the established goals:**
    - **Produce member-level profiles for physicians**
    - **Support adherence to clinical practice guidelines**
    - **Identify members at risk for chronic and acute diseases that may need interventions or case management**
    - **Promote a higher standard of care.**

- **DCH has assumed full responsibility for the production and processing of Data Quality Improvement Packets (DQIP). The DQIP program is design to improve the quality and accuracy of the encounter data submitted by the Medicaid Health Plans and stored in the DCH Data Warehouse. DCH has completed at least one DQIP meeting with each MHP and continue to explore avenues for improving the usefulness of this data.**

Currently, Michigan Department of Community Health (MDCH) contracts with Medicaid health plans (MHP), to provide a comprehensive set of health care services for over 1 million of the State's Medicaid beneficiaries.

In the last waiver period from July 2007 through June 2009 the state has implemented the following initiatives:

- **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. Historically, issues of continuity of care and access to care have prevented Michigan from establishing pregnant women as a mandatory population. However, HEDIS scores and other measures indicate that pregnant women will have access to high quality pre-natal and post-partum care through the MHPs. Most MHPs have greatly expanded the plan's provider network decreasing the access to care concern. And, continuity of care issues are minimized because MHPs are required to allow pregnant**

women with new Medicaid eligibility to continue care with their established providers, even if those providers are not contracted with the MHP. Michigan Enrolls is monitoring helpline calls from these pregnant women and have reported no significant issues. DCH staff is monitoring the MHPs' processes for facilitating care for this population through focus studies at the annual on-site visits.

- **Subsequent to the policy decision to enroll all pregnant women into MHPs, DCH established a Transition of Pregnant Women Workgroup in order to facilitate the smooth transition from fee for service to managed care for these women and ensure continuity of care. A major issue for this transition was the decision to "carve out" the Maternal/Infant Health Program (MIHP) from the benefit package of the MHPs. Therefore, the group began discussions in March of 2008, with formal meetings beginning in July of 2008, to develop guidelines for coordination between MHPs and MIHP providers to ensure access to services for the pregnant women population. Stakeholders in attendance for discussions were the Local Public Health Offices, Nurse Administrators at Local Public Health, the MIHP providers, the MHPs, and DCH administration. The discussion covered a variety of topics; however, the major issues were referrals from MHPs for out-of-network services, referrals from MHPs for MIHP services, transportation, behavioral health and coordination of care. The workgroup continues to meet to assure all transition issues are addressed in a timely manner. As of this date, the workgroup is accomplishing their goals and the transition of pregnant women into MHPs is progressing without major issues.**

- **On 4/3/06, the Michigan Health Information Network (MiHIN) officially began a project to convene Michigan's health care stakeholders to speed the adoption of health information technology and promote health information exchange. Beginning fiscal year 2008, DCH expanded the MHP performance bonus program to engage the MHPs in HIE/HIT. For the 2008 award, the MHPs were required to initially establish relationships with the Regional Health Information Exchanges within their service region around the State. For 2009 bonus award, the MHPs are required to actively educate/engage their providers in the use of E-prescribing practices. Additionally, DCH is participating in a project entitled "Reducing Disparities at the Practice Site." Within the context of this three year project, one of the elements of focus is that the practice sites build a quality infrastructure and care management capacity to achieve Patient Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA). In order to ensure effective implementation and sustainability, DCH is educating and engaging the MHPs in the patient centered medical home concept and activity beyond the three year project. PCMH activities are included in the re-bid for 2009 as well as the 2010 performance bonus award.**

- **DCH developed a program to collect basic healthy behavior information from Medicaid beneficiaries at the time of enrollment in the MHPs. DCH worked with the State's enrollment contractor, Michigan Enrolls, to develop a brief screening survey that the phone enrollment counselors could utilize during the enrollment process. The Michigan Enrolls Call Center began conducting healthy lifestyle screening (HLS) surveys on 10/1/08. Michigan Enrolls prepare plan-specific files with HLS results for each MHP for their new enrollees to download. MHPs then use the information to assign members to case management, to provide educational material, etc. Michigan**

Enrolls reports the data to DCH on a quarterly basis. DCH staff is monitoring the MHPs' use of the data received via the HLS program through focus studies at the annual site visits.

- **One of the major projects in the most recent waiver period is the design and development of a new Medicaid Management Information System (MMIS). The new system, Community Health Automated Medicaid Processing System (CHAMPS), replaces the current MMIS that has been in place for approximately 25 years. CHAMPS will improve the efficiency and effectiveness of capitation payments and recoupments, allow DCH to track expenditures through ad hoc reporting, and make network and PCP information more readily available. One of the key features is the automation of recoupments and payments based on changes in rates or changes in beneficiary's eligibility.**

- **The CHCP is a competitively bid program. A new bid was released 3/6/09 with contract begin dates of 10/1/09. The most recent bid maintained the focus on quality and access. Bidders are required to show a minimum threshold of administrative requirements in order to be evaluated. The points are awarded based on the strength of the bidders network and HEDIS scores for specific measures:**
    - **Chlamydia Screening Rate (combined rate)**
    - **HbA1c Testing Rate**
    - **LDL Screening Rate**
    - **Rate for Well Child Visits for Children 3 – 6 years old**
    - **Adolescent Well Child Visit Rate**

  As a value-based health care purchaser, Michigan holds providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. During the process of bid evaluation, Michigan will consider Bidder capabilities that provide added value to the State related to the following:
    - **Health Information Exchange**
    - **Population management experience for the disabled**
    - **Provider incentives to encourage development of Patient Centered Medical Home**
    - **National award recognition for consumer engagement and clinical improvement initiatives**
    - **Care coordination for persons with mental illness**

A. Statutory Authority

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. **X** **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.

b. **X** **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.

c. **N/A** **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.

d. **X** **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).

The 1915(b)(4) waiver applies to the following programs

- **X** 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)

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. **X** **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. **Depending upon contracting HMOs and their provider networks, this waiver program may not be available throughout the state.**

b. **X** **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.

c. **X** **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.

d. **N/A** **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).

e. **N/A** **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.

B. Delivery Systems

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

a. **X** **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. **N/A** **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. **N/A** **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. **N/A** **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. **N/A** **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

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

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):

X **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

The contractor is at-risk for inpatient hospital services and any of the following services:

- **Outpatient hospital services**
- **Rural health clinic (RHC) services**
- **Federally qualified health clinic (FQHC) services**
- **Other laboratory and x-ray services**
- **Early periodic screening, diagnosis and treatment (EPSDT) services**
- **Family planning services**
- **Physician services**
- **Home Health services.**

N/A **Open** cooperative procurement process (in which any qualifying contractor may participate)

N/A **Sole source** procurement

N/A **Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

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.

N/A The State seeks a waiver of section 1902(a)(4) 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):

_X_ Two or more MCOs
N/A Two or more primary care providers within one PCCM system.
N/A A PCCM or one or more MCOs
N/A Two or more PIHPs.
N/A Two or more PAHPs.
_X_ Other:
Rural Exception (See below)
Preferred Option: The DCH 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. (See Attachment A, Medicaid Managed Care Contract, Section II-F, 5, pg. 27).

3. **Rural Exception.**

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

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

N/A Beneficiaries will be limited to a single provider in their service area (please define service area).
X Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

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.

X **Statewide** -- all counties, zip codes, or regions of the State

N/A **Less than Statewide**

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. **Please see updated table beginning on next page.**

County	MCOs available
Alcona	CareSource
	Molina Healthcare of MI
Alger	Upper Peninsula Health Plan
Allegan	CareSource
	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs
Alpena	CareSource
Antrim	CareSource
Arenac	CareSource
	McLaren Health Plan
	Molina Healthcare of MI
Baraga	Upper Peninsula Health Plan
Barry	Health Plan of MI
Bay	HealthPlus Partners, Inc.
	McLaren Health Plan
	Molina Healthcare of MI
Benzie	CareSource
	Molina Healthcare of MI
Berrien	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Branch	Great Lakes Health Plan
	Health Plan of MI
Calhoun	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Cass	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Charlevoix	CareSource

County	MCOs available
Cheboygan	CareSource
Chippewa	Upper Peninsula Health Plan
Clare	Molina Healthcare of MI
Clinton	Health Plan of MI
	McLaren Health Plan
Crawford	CareSource
	Health Plan of Michigan
	McLaren Health Plan
	Molina Healthcare of MI
Delta	Upper Peninsula Health Plan
Dickinson	Upper Peninsula Health Plan
Eaton	Health Plan of MI
	McLaren Health Plan
Emmet	
Genesee	CareSource
	Health Plan of MI
	HealthPlus Partners, Inc.
	McLaren Health Plan
	Molina Healthcare of MI
	Total Health Care
Gladwin	CareSource
	Molina Healthcare of MI
Gogebic	Upper Peninsula Health Plan
Gr. Traverse	CareSource
Gratiot	McLaren Health Plan
	Molina Healthcare of MI
Hillsdale	Great Lakes Health Plan
	Health Plan of MI
Houghton	Upper Peninsula Health Plan
Huron	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI

Ingham	McLaren Health Plan
	PHP-MM Family Care
Ionia	CareSource
	McLaren Health Plan
	Molina Healthcare of MI
	PHP-MM Family Care
Iosco	CareSource
	Molina Healthcare of MI
Iron	Upper Peninsula Health Plan
Isabella	McLaren Health Plan
	Molina Healthcare of MI
Jackson	Great Lakes Health Plan
	Health Plan of MI
Kalamazoo	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Kalkaska	CareSource
Kent	CareSource
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Keweenaw	Upper Peninsula Health Plan
Lake	CareSource
	Health Plan of Michigan
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Lapeer	HealthPlus Partners, Inc.
	McLaren Health Plan
Leelanau	CareSource
Lenawee	Great Lakes Health Plan
	Health Plan of MI
Livingston	BlueCaid
	Great Lakes Health Plan
	Health Plan of MI
	Midwest Health Plan

Luce	Upper Peninsula Health Plan
Mackinac	Upper Peninsula Health Plan
Macomb	Great Lakes Health Plan
	Health Plan of MI
	McLaren Health Plan
	Midwest Health Plan
	Molina Healthcare of MI
	OmniCare Health Plan
	Total Health Care
Manistee	CareSource
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Marquette	Upper Peninsula Health Plan
Mason	CareSource
	Health Plan of Michigan
	Molina Healthcare of MI
Mecosta	CareSource
	Health Plan of Michigan
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Menominee	Upper Peninsula Health Plan
Midland	Molina Healthcare of MI
Missaukee	CareSource
	Molina Healthcare of MI
Monroe	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI
Montcalm	Health Plan of MI
	McLaren Health Plan
	Molina Healthcare of MI
	PHP-MM Family Care
	Priority Health Govt. Programs, Inc.
Montmorency	CareSource
	Molina Healthcare of MI
Muskegon	CareSource
	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Newaygo	CareSource
	Health Plan of MI
	Molina Healthcare of MI

Oakland	Great Lakes Health Plan
	Health Plan of MI
	McLaren Health Plan
	Midwest Health Plan
	Molina Healthcare of MI
	OmniCare Health Plan
	Total Health Care
Oceana	CareSource
	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Ogemaw	CareSource
	Health Plan of MI
	McLaren Health Plan
	Molina Healthcare of MI
Ontonagon	Upper Peninsula Health Plan
Osceola	CareSource
	Health Plan of Michigan
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Oscoda	CareSource
	Health Plan of MI
	McLaren Health Plan
	Molina Healthcare of MI
Otsego	Health Plan of Michigan
	Molina Healthcare of MI
Ottawa	CareSource
	Health Plan of MI
	Molina Healthcare of MI
	Priority Health Govt. Programs, Inc.
Presque Isle	CareSource
	Molina Healthcare of MI
Roscommon	CareSource
	Health Plan of MI
	McLaren Health Plan
	Molina Healthcare of MI

Saginaw	CareSource
	Great Lakes Health Plan
	Health Plan of MI
	HealthPlus Partners, Inc.
	McLaren Health Plan
	Molina Healthcare of MI
Sanilac	Great Lakes Health Plan
	Health Plan of MI
	Molina Healthcare of MI
Schoolcraft	Upper Peninsula Health Plan
Shiawassee	Health Plan of Michigan
	HealthPlus Partners, Inc.
	McLaren Health Plan
	PHP-MM Family Care
St. Clair	Great Lakes Health Plan
	Health Plan of MI
	Midwest Health Plan
	Molina Healthcare of MI
St. Joseph	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Tuscola	Great Lakes Health Plan
	Health Plan of MI
	HealthPlus Partners, Inc.
	McLaren Health Plan
	Molina Healthcare of MI
Van Buren	CareSource
	Great Lakes Health Plan
	Health Plan of MI
Washtenaw	BlueCaid
	Midwest Health Plan
Wayne	BlueCaid
	Great Lakes Health Plan
	Health Plan of Michigan
	Midwest Health Plan
	Molina Healthcare of MI
	OmniCare Health Plan
	ProCare
	Total Health Care
Wexford	Molina Healthcare of MI

MCO Name	Service Area
BlueCaid	Livingston, Washtenaw, Wayne
CareSource	Alcona, Allegan, Alpena, Antrim, Arenac, Benzie, Berrien, Calhoun, Cass, Charlevoix, Cheboygan, Crawford, Genesee, Gladwin, Grand Traverse, Ionia, Iosco, Kalamazoo, Kalkaska, Kent, Lake, Leelanau, Manistee, Mason, Mecosta, Missaukee, Montmorency, Muskegon, Newaygo, Oceana, Ogemaw, Osceola, Oscoda, Ottawa, Presque Isle, Roscommon, Saginaw, St. Joseph, Van Buren
Great Lakes Health Plan	Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Huron, Jackson, Kalamazoo, Lenawee, Livingston, Macomb, Monroe, Muskegon, Oakland, Oceana, Saginaw, Sanilac, St. Clair, St. Joseph, Tuscola, VanBuren, Wayne
Health Plan of Michigan	Allegan, Barry, Berrien, Branch, Calhoun, Cass, Clinton, Crawford, Eaton, Genesee, Hillsdale, Huron, Jackson, Kalamazoo, Kent, Lake, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, St. Clair, St. Joseph, Shiawassee, Tuscola, Van Buren, Wayne
HealthPlus Partners, Inc.	Bay, Genesee, Lapeer, Saginaw, Shiawassee, Tuscola
McLaren Health Plan	Arenac, Bay, Clinton, Crawford, Eaton, Genesee, Gratiot, Ingham, Ionia, Isabella, Lapeer, Macomb, Montcalm, Oakland, Ogemaw, Oscoda, Roscommon, Saginaw, Shiawassee, Tuscola
Midwest Health Plan	Livingston, Macomb, Oakland, St. Clair, Washtenaw, Wayne
Molina Healthcare of MI	Alcona, Allegan, Arenac, Bay, Benzie, Clare, Crawford, Genesee, Gladwin, Gratiot, Huron, Ionia, Iosco, Isabella Kent, Lake, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, St. Clair, Sanilac, Tuscola, Wayne, Wexford
OmniCare Health Plan, Inc.	Macomb, Oakland, Wayne
PHP-MM Family Care	Ingham, Ionia, Montcalm, Shiawassee
Priority Health Government Programs, Inc.	Allegan, Kent, Lake, Manistee, Mecosta, Montcalm, Muskegon, Oceana, Osceola, Ottawa
ProCare	Wayne
Total Health Care	Genesee, Macomb, Oakland, Wayne
Upper Peninsula (UP) Health Plan	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

E. Populations Included in Waiver

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:

X **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- _X_ Mandatory enrollment
- ___ Voluntary enrollment

_X_ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- _X_ Mandatory enrollment
- ___ Voluntary enrollment

_X_ **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.

- _X_ Mandatory enrollment
- ___ Voluntary enrollment

_X_ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- _X_ Mandatory enrollment
- ___ Voluntary enrollment

N/A **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

X **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.

- _X__ Mandatory enrollment
- ___ Voluntary enrollment

N/A **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

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:

X **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))

N/A **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. **(managed care/HMO)**

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).

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

N/A **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).

N/A **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 Childrens' 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.

N/A **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

_**X**__ **Other** (Please define): **Spenddown, childcare institutions, refugee assistance programs and repatriate assistance programs.**

The CHCP does not list special populations but requires Contracting MCOs to meet the special health needs of the enrolled population and to the degree the population is not covered in any other category. **Those children participating in the Children's Waiver are excluded from CHCP enrollment.**

F. Services

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

1. **Assurances.**

_**X**__ 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).

_**X**__ 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.

N/A 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.

_**N/A** 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.
This is not applicable to the Michigan 1915(b) waiver since Dual Eligibles are an excluded population under 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.

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.

N/A The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

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

_**X**_ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

N/A 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

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

___ Other (please explain):

N/A Family planning services are not included under the waiver.

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:

N/A 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 Attachment A, Medicaid Managed Care Contract, Section II-H, 5, pg. 37, Federally Qualified Health Centers)

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

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.

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

N/A 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.

7. **Self-referrals.**

_**X**__ 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:

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

Under the CHCP Contract, Medicaid beneficiaries may seek the following covered services without prior authorization:

- ✓ **Immunization and communicable disease management from local Public Health Departments regardless of network affiliation, (See Attachment A, Medicaid Managed Care Contract, Section II-H, 10 & 13, pgs. 40-41)**
- ✓ **Routine OB/GYN and pediatric services from network providers; (See Attachment A, Medicaid Managed Care Contract, Section II-S, 3, pg. 70)**
- ✓ **Child & Adolescent Health Centers regardless of network affiliation. (See Attachment A, Medicaid Managed Care Contract, Section II-H, 15, pg. 42)**

Section A: Program Description

Part II: Access

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.

A. Timely Access Standards

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 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, 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.

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. **N/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):

b. **N/A 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):

c. **N/A 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):

d. **N/A Other Access Standards** (please describe)

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.

B. Capacity Standards

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 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, 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.

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.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

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

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	***PCCM-to-Enrollee Ratio***
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

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.

C. Coordination and Continuity of Care Standards

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 438.208 Coordination and Continuity of Care, 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, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. 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.

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. _X_ **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. **(See Attachment B, Transitioning CSHCS Clients with Medicaid Who Are Aging Out of CSHCS)**

c. _X_ **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. **(See Attachment B, Transitioning CSHCS Clients with Medicaid Who Are Aging Out of CSHCS)**

d. _X_ **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:

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.

1.**X** Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.**X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.**X** In accord with any applicable State quality assurance and utilization review standards.

e. **X** **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.
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. (See Attachment A, Medicaid Managed Care Contract, Section II-L, 7i, pg. 58)

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

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 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.

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 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 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 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 _____.

_**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	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) Validation of PIP**	
PIHP				

2. **Assurances For PAHP program.**

N/A 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 a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above 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.

N/A 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.

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. **N/A** The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. **N/A** **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

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; and

15.___ Other (explain):

c. **N/A** **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 describe).

d. **N/A Other quality standards** (please describe):

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

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

_**X**__ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of 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(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.

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

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. _**X**__The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

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

1. **X** 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 DCH, contractors 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 contractor 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 contractor. DCH will review and approve any form of marketing.**
The CHCP program monitors compliance through the following:
   - **Contract enforcement**
   - **Formal and informal communication**

   Health plan marketing is assessed as part of the CHCP Program's annual site review of each contracting MCO. The HMO Contract specifies that prior approval is necessary before any "permissible" marketing activity is undertaken and describes the prohibited marketing activities and locations. (See Attachment A, Medicaid Managed Care Contract, II-R, pg. 76)

   The second mechanism of oversight is providing clarification through official communication. The CHCP program also uses the relationship with the State's Enrollment Services Contractor to provide information to Medicaid beneficiaries regarding health plan details that previously may have been provided by individual health plan marketing staff. (See Attachment C, Michigan Enrolls Contract for more details on the health plan information provided to beneficiaries).

2. **N/A** 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. **X** The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

   The State has chosen these languages because (check any that apply):
   - i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
   - ii. **X** The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
   - iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

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.

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

2. **Details.**

a. **Non-English Languages**

_**X**__ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

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

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. **X**_ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

___ _**X**__ 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. (See Attachment A, Medicaid Managed Care Contract, Section II-S, pg. 69-72).

_**X**__ 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. (See Attachment A, Medicaid Managed Care Contract, Section II-S, pg. 69-72).**

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.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

N/A State
_**X**_ 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 DCH before presentation. (See Attachment A, Medicaid Managed Care Contract, Section II-R, 3-4, pg. 68-69)

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

c. Enrollee Information

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

(i) ___ the State
(ii) _**X**_ State contractor (please specify):_MI ENROLLS_____
(ii) ___ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

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 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. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_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.

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. _X_ **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:
DCH staff, including staff in the CHCP Program, continue to provide frequent presentations for provider groups, health care coalition meetings, and consumer groups. The DCH 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.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

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

_**X**__ 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:

_**X**__ choice counseling
_**X**__ enrollment
_**X**__ 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 as noted in the Monthly enrollment statistics (See Attachment D, Enrollment Packet).

The CHCP Contract requires each of the MCOs to submit provider files to the Enrollment Services Contractor. The provider files contain a complete description of the provider network available to enrollees, (See Attachment A, Medicaid Managed Care Contract, Section II-L, 7). The contract requires the files to be provided in a format specified by the MDCH, updated as necessary to reflect changes in the network, and submitted to MICHIGAN ENROLLS in a timely manner. Further, the CHCP program has developed a contractual performance standard regarding the timely and completeness of submission of provider files. This is a performance requirement and ensures that the information provided to beneficiaries is current. (See Attachment E, Performance Monitoring Standards).

All counselors hired by Maximus, (dba MICHIGAN ENROLLS) are given 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 the 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.

All beneficiaries enrolled in Medicaid MCOs are notified during the annual open enrollment period regarding their ability to make an alternative choice. Open enrollment letters are distributed in time for beneficiaries to contact the enrollment broker, Michigan Enrolls, during the period May 1-31 of each year. The effective date of open enrollment changes is July 1st of

each year. Subsequently, any beneficiary who chose an alternative MCO will have an additional 90 days after July 1st in the event he or she wish to make another change. (See Attachment A, Medicaid Managed Care Contract, Section II-F, pg. 26).

- **New member packets are sent out to new members**
- **In 20 days, a new member is auto-assigned to HMO, if no response is received. The new member is assigned to a comprehensive MCO, which, by definition, can suit his/her needs.**
- **A beneficiary may request an exception to enrollment in the MCO 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.**

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

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

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

i. _**X**_ Potential enrollees will have_**20**___days/month(s) to choose a plan.
ii. _**X**_ Please describe the auto-assignment process and/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%. Changes were made effective on January 1, 2009.

_**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: **DCH implements the preferred option program in the following counties: Alpena, Antrim, Barry, Charlevoix, Grand Traverse, Isabella, Leelanau, Otsego, and Wexford. 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 MCO 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. (See Attachment A, Medicaid Managed Care Contract, II-F-12, pg. 31, Medical Exception.)

_**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. **Michigan uses a loss of 3 months or less.**

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.

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

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

_**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 that 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): **This pertains to the mandatory population.**

_**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. **This pertains to the voluntary populations of Native Americans and migrant workers.**

_**X**__ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.
Please check items below that apply:

i._**X**__ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
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

- **Error**
- **Out of service area**
- **Dual eligible**
- **Incarceration**

Long Term Care disenrollment from health plan

- **The MCO requests the State to disenroll an enrollee for the purpose of custodial placement in a long term care facility. The State reviews and approves the disenrollment and enrolls the client in the 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.
If the enrollee is unable to change plans, s/he is returned to FFS. (For administrative disenrollment only)

D. Enrollee rights.

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 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)(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.

E. Grievance System

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 Federal Regulations found at 42 CFR 431 Subpart E.

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.

___ 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 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(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.

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** calendar days.

c. **Special Needs**

_**X**__ The State has special processes in place for persons with special needs. Please describe. **The MCO 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 MCO must provide interpreter services and toll free numbers for enrollee questions and assistance. (See Attachment A, Medicaid Managed Care Contract, section II-T, 1, pg. 73.)**

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.

_**N/A** 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 is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ 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, which is: _____ (please specify for each type of request for review)

___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

___ Establishes and maintains an expedited review process for the following reasons:_____ . 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):

F. Program Integrity

1. **Assurances.**

_**X**__ 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.

__**X**_ 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.

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 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 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 B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to 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 on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication	N/A	→	→	→	→	→	→	→	→	→	→	→
Accreditation for Participation	X				X							
Consumer Self-Report data	X				X		X					X
Data Analysis (non-claims)			X	X				X		X		
Enrollee Hotlines	X		X		X							
Focused Studies												X
Geographic mapping								X				
Independent Assessment	N/A→	→	→	→	→	→	→	→	→	→	→	→
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy Assurance by Plan	X							X			X	

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Ombudsman	N/A→	→	→	→	→	→	→	→	→	→	→	→
On-Site Review				X	X	X	X	X	X	X	X	X
Performance Improvement Projects												X
Performance Measures						X	X	X				X
Periodic Comparison of # of Providers	X							X				
Profile Utilization by Provider Caseload	N/A→	→	→	→	→	→	→	→	→	→	→	→
Provider Self-Report Data	N/A→	→	→	→	→	→	→	→	→	→	→	→
Test 24/7 PCP Availability							X					
Utilization Review										X		X
Other: (describe) Review of member material distributed		X			X				X			

II. Details of Monitoring Activities

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:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- 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. **N/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)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

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

_x_ NCQA
___ JCAHO
___ AAAHC
_x_ Other (please describe) **URAC**

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.

c. **X** Consumer Self-Report data.

_x_ CAHPS (please identify which one(s)) **The most current version of CAHPS Adult & Child**

___ State-developed survey

___ Disenrollment survey

___ Consumer/beneficiary focus groups

Per MCO contract with the State, the health plan is required to submit an annual Adult CAHPs survey conducted by a certified vendor. The State is contracted with a certified CAHPS vendor to conduct the child survey every other year beginning with 2005. The CAHPS results are utilized in the consumer guide scoring categories and the performance bonus award. The CAHPS is also used to assess beneficiary satisfaction with their experience of healthcare. The aggregate CAHPS results provide important program information as part of the State's overall quality improvement strategy.

d. __**X**__ Data Analysis (non-claims)

___ Denials of referral requests

_x_ Disenrollment requests by enrollee

_x_ From plan

___ From PCP within plan

_x_ Grievances and appeals data

___ PCP termination rates and reasons

_x_ Other Provider File

The State generates reports from the Beneficiary Provider Contacts Tracking (BPCT) log quarterly. These reports are used to evaluate enrollment and disenrollment trends, potential program integrity (fraud/abuse) issues, and coverage and authorizations. 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.

e. __**X**__ Enrollee Hotlines operated by State

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. __**X**__ 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).

While, the state is not conducting the optional focused study through the EQRO at this time, the State maintains this option in the contract

with the EQRO vendor. DCH conducts specific focused reviews referred to as Focused Study in the State's onsite activity. DCH focuses on specific issues both clinical and non-clinical that require a more in-depth review.

g. __**X**__ Geographic mapping of provider network
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 onsite activity and intermittently for service area requests. This information is used by the plans and State to assess and provide evidence of provider capacity and access.

h. _**N/A**_ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)
Michigan completed requirement in 2001.

i __**X**_ Measurement of any disparities by racial or ethnic groups

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, 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. U of M is currently analyzing the data provided by the plans.

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.

__**X**__ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

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. _**N/A**_ Ombudsman

l. __**X**__ On-site review

State staff conducts annual onsite review 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. Onsite visit reports summarize review findings and identify needed action and opportunities for improvement. The onsite review also obtains information on best practices of the health plans.

m. _**X**__ Performance Improvement projects [**Required** for MCO/PIHP]

_x_ Clinical

_x_ Non-clinical

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.

n. __**X**__ Performance measures [**Required** for MCO/PIHP]

Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

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 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.

o. __**X**__ Periodic comparison of number and types of Medicaid providers before and after waiver.
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. _**N/A**_ Profile utilization by provider caseload (looking for outliers)

q. _**N/A**_ Provider Self-report data
___ Survey of providers
___ Focus groups

r. __**X**__ Test 24 hours/7 days a week PCP availability
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 on site review.

s. __**X**__ Utilization review (e.g. ER, non-authorized specialist requests)
The State and health plans conduct utilization review. As part of the annual site visit, the State assures that the plan has a Utilization Management Program that governs the plans utilization review and decision-making.

t. __**X**__ Other: (please describe)

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 – New Information

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 an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

_**X**_ 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.
- _**X**__ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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.

Please replicate the template below for each activity identified in Section B:

The DCH conducts annual "onsite" compliance reviews of each contracted health plan, to assess access and availability, capacity, quality and program integrity. The EQRO contractor conducts an assessment of the State's "compliance review" or

onsite activity. The onsite criteria address all the monitoring activities as described in section B. At the conclusion of the annual contract compliance review, DCH creates a findings report to provide feedback and request an action plan from the health plans. DCH conducts follow-up of findings between or at the next onsite visit depending on its severity. The EQR contractor utilizes the onsite summary file and other documentation to provide and assessment of MCO compliance with the standards as it relates to Access, Quality and Timeliness.

Strategy: I. Access Standards
Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:
The State has Established contract requirements regarding:

a. Availability Standards:
- Services are available to enrollees within 30 minutes or 30 miles for PCP, and Hospitals. (Exceptions to this standard may be granted if the health plan documents that no other network or non-network provider is accessible within the 30 minute or 30 mile travel time.
- Pharmacy service access within 30 minutes and available during evening and weekends
- Provisions for urgent/emergent services available 24/7
- PCPs Provide or arrange for coverage of services 24/7 (by toll free number)
- PCP available to see enrollees a minimum of 20 hours per practice location per week.

b. Appointment Scheduling:
- Health plans establish criteria for monitoring appointment scheduling for routine and urgent care and monitor waiting times to get appointments with providers

c. In-office Waiting Times:
- Health plans monitor the length of time actually spent waiting to see provider in the office.

These standards are also monitored through the onsite activity and the CAHPS. DCH reviewed the plans over the past waiver period for these standards and 100% of the plans met the standard.

Problems identified:
None

Corrective action (plan/provider level):
None

Program change (system-wide level):
None

Strategy: II. Access and Availability Monitoring
Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results:
The access and availability monitoring activities identified in section B part II, were conducted through onsite review, focused studies, and analysis of various reports by the State and/or designated entities.

- Through the onsite reviews, the majority of the health plans demonstrated appropriate access standards and were meeting the State's availability standards as defined by the contract. Those plans not meeting these standards had various interventions in place.
- DCH monitors several access to care HEDIS measures including Children's and Adolescents' Access to Primary Care Practitioners (four age cohorts) and Adults' Access to Preventive/Ambulatory Health Services (two age cohorts).

Problems identified:
At least half the plans were below the NCQA 50th percentile for four of the five age cohorts for the 2004 HEDIS access to PCP/Preventive Health Services measures. 2005 HEDIS data showed additional plans not meeting the standard for this measure. 2006 and 2007 HEDIS data showed improvement in all of the access to care measures, although still not statistically significant improvement.

Corrective action (plan/provider level):
A mandatory access to care performance improvement project was required of the 8 plans below the standard for 2005. The Access to Care improvement project was broadened to a statewide project with all the health plans participation for FY 2007. Technical assistance was provided through a Center for Health Care Strategies (CHCS) grant for a state initiative titled Practice Size Exploratory Project (PSEP).
Building on this PSEP project, Michigan is participating in the Reducing disparities at the Practice Site (RDPS) project, a three-year project that will work the build the quality infrastructure and care management capacity of small practices that see a majority of Medicaid patients.

Strategy: III. Capacity Standards
Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results:

DCH continues to implement the stringent capacity standard by requiring a ratio of PCP to members of 1:750. DCH has determined that this standard facilitates Michigan's ability to maximize the resources of MHPs without creating impediments to access to care.

Problems identified:
Overall, the Medicaid Health Plans comply with the 1:750 PCP to member ratio. DCH also examines the PCP to member ratio on an individual county and regional level for each plan.

Corrective action (plan/provider level):
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 access to PCPs.

Program change (system-wide level):
The State continues to utilize a county-level PCP capacity component in the auto-assignment algorithm. Plans are rewarded points toward the overall score used for auto-assignment algorithm based on the ratio of PCPs to established capacity in each county. To be included, the PCP must be accepting both new and existing patients. Plans with a ratio of 1:500 or better are rewarded 28 points (approximately 25% of possible points); plans with a ratio between 1:500 and 1:750 are rewarded 14 points; otherwise, the plan receives no points for this component of the algorithm.

Strategy: IV. Capacity Monitoring
Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:
During the previous waiver period, Michigan conducted all identified capacity monitoring activities, which include:

- Provider to enrollee ratio
- Periodic MCO reports on provider network
- Tracking of complaint and grievances concerning capacity issues
- Consumer experience survey

During this waiver period, the capacity was evaluated based on data received from the State's enrollment broker, MI Enrolls. MI Enrolls gathers the provider network data through electronic file submission by the Medicaid Health Plans. The contract requires plans to submit provider network information to MI Enrolls each month. Currently, all contracted health plans meet capacity standards in their respective service areas. The Department also tracks provider capacity annually during the onsite activity and as

capacity needs change. Capacity impacts not only access to care but also financial solvency of the Medicaid Health Plans.

Problems identified: None

Corrective action (plan/provider level): None.

Program change (system-wide level):
The Department continues to use the enhanced monitoring standards for the Medicaid Health Plan's provider file submission that was implemented in the previous waiver period. The Provider File Performance Monitoring Standard requires the plan to submit at least one error-free provider file per month to MI Enrolls. Error free status is measured in terms of file structure/ data layout and content. Provider files must pass edits on data fields such as valid license numbers, correct provider identification, and accurate specialty codes. Occasionally DCH receives information from providers and enrollees indicating discrepancies in the provider files. Plans are required to resolve any discrepancies in the provider files within 30 days. In preparation for the transition to the new Medicaid Management Information System, the Department has also increased requirements for data elements such as office hours, pediatric services and OB/GYN services.

Strategy: V. Continuity and Coordination of Care Standards
Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

- The MCOs continue to be required to offer enrollees freedom of choice in selecting a PCP. Each MCO has written policies and procedures describing its process. Michigan Enrolls continues to conduct the State auto-assignment process into a health plan if the enrollee does not make a selection. The State establishes criteria for assignment.
- The health plans are required to provide health education/promotion to its members and is monitored in the onsite review process.
- Provider maintenance of member health record is monitored by the health plan and the process is reviewed by the State during onsite visits. The plans are required to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996.
- The health plans must establish and maintain agreements with local behavioral health and developmental disability agencies (CMHSPs). The health plans must coordinate care for enrollees requiring integration of medical and behavioral health/substance abuse care.
- The health plans are required to provide case management and care coordination services.

- During the past waiver period, DCH implemented mandatory coordination of care agreements between the MHPs and Maternal and Infant Health services providers.

Problems identified:
Specialized Mental health services, Substance abuse and Developmental Disability services are covered under the CMHSPs or Prepaid In-patient Health Plan (PIHPs). Substance abuse services are covered under the CMHSPs through contracts with Substance Abuse Coordinating Agencies. Coordination between MHPs and the mental health/substance abuse agencies has improved over the past waiver period; however, consistent and programmatic coordination is still inconsistent across counties in the State.

Corrective action (plan/provider level)
The State continues to maintain collaboration with our mental health agency partners through the Mental Health Advisory Committee (MHAC). This committee is established to facilitate coordination between the community mental health providers and the health plans. During the past waiver period, the MHAC chartered an ad hoc committee to address specific concerns relating to coordination between the MHPs and the mental health agencies. As of the waiver submission, the ad hoc committee has nearly completed its work. Key outcomes of this committee include: (1) An L-letter to all health plans detailing the Department's expectations regarding treatment of individuals with co-occurring disorders (mental health and substance abuse; (2) A new access tool for physicians to assists them in access the correct agency for referral of a client with a mental health or substance abuse issue; and (3) A detailed responsibility grid that delineates referral and payment responsibility for circumstances involving an overlap of physical, mental health, and substance abuse issues.

Program change (system-wide level)
During the past waiver period, DCH began facilitating data sharing between, MHPs and PIHPs. In one highly-populated county in Michigan, the PIHP and an MHP that serves that county, have begun a data sharing project. Both entities report that data received is improving coordination of care at the individual level.

Strategy: VI. Continuity and Coordination of Care Monitoring
Confirmation it was conducted as described:

_x_ Yes
__ No. Please explain:

Summary of results:
DCH continues to monitor the continuity and coordination of care between the MCOs and other providers, such as, FQHC, LHD, WIC, CMHSPs, PIHPs, MIHPs and Dental providers.

- DCH monitors the health plan process of member PCP selection and assignment through the onsite review. In the last review period, DCH determined that all plans were compliant with PCP selection and assignment for voluntary members.

However, DCH found two plans needed improvement in the PCP assignment process for auto-assigned member. DCH advised the plans on the aspects needing improvement and will review these aspects at the next site visit.

- The health plan education/promotion materials and activities continue to be reviewed prior to distribution to members and during onsite process. None of the 13 plans had any actionable findings from the review of member educational materials.
- DCH reviewed the plans for evidence of coordination and continuity of care with behavioral health providers. The state conducted a review of coordination of care with Community mental health providers and found that most MHPs maintained coordination of care agreements with all PIHPs/CMHSPs in their service area; two plans were in the process of renewing/obtaining agreements with one PIHP. None of the plans had actionable findings.
- DCH continues to monitors the health plans compliance with medical records and HIPAA requirements through review of compliance officer/committee activities. All plans had no findings for this criterion.
- Over the past waiver period, the Department conducted a focus study in MHPs regarding EPSDT outreach. Of the plans reviewed, DCH determined that the MHPs were compliant with the contract requirements.
- The State reviews the health plans case management/disease management (CM/DM) process for coordination standards, access to health care services and coordination of care for all its enrollees and particularly the State's defined Persons with Special Health Care Needs (PSHCN) population. The State has conducted an initial survey, and in collaboration with the Michigan State University Institute for Health Care Studies (IHCS), conducted a comprehensive assessment of Medicaid health plan disease and case management programs.

Problems identified:
The types and range of information provided by the MHPs varied.

Corrective action (plan/provider level):

- EPSDT: All deficiencies noted during the focus study were minor and DCH worked with the MHP at the time of the on-site to identify actions needed by the plan.
- CM/DM: State staff is currently conducting follow-up of the assessment findings through its annual onsite review of the health plans.

Program change (system-wide level):

- EPSDT: Based on the variety of information provided, DCH revised the data collection methods for EPSDT outreach
- CM/DM: Contract language has been updated in the current RFP to define and distinguish disease management and case management.