STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 9, 2010

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Ms. Johnson:

This letter is in response to your correspondence of May 3, 2010, received on May 10, 2010, informing Michigan that CMS approved the state's request for renewal of its Medicaid Managed Specialty Services and Supports Program, control #MI-14.R05, effective May 1, 2010 through April 30, 2011. This letter and its signature substitute for the signature page provided in the approval letter.

Michigan continues to believe that its implementation of the concurrent waivers for Michigan citizens who require supports and services from the Managed Specialty Services and Supports program has been demonstratively successful in achieving a rebalancing of options toward the stated intent of the Michigan Mental Health Code, the ADA and the Olmstead decision, and of the overall intent of CMS and congressional policy toward individuals with significant disabilities served through the Medicaid program.

In pursuit of meeting CMS requirements and assurances, then, Michigan provides critical additional perspective to CMS on the objectives and outcomes central to the state's goal of operating the concurrent waiver program successfully for those served. Thus, with respect to working with CMS in the context of the Special Terms and Conditions, Michigan needs to be able to assure:

- That there continues to be made available a flexible range of medically necessary services and supports that can be applied within the framework of the Medical Necessity definition for the existing 1915(b)(3) services such that the program allows Michigan beneficiaries to access services and supports in community settings that promote recovery, independent living and self-direction, and which are cost-efficient and cost-effective;

- That Michigan's beneficiaries have access to benefits that are entitlements that they can count upon, rather than simply being afforded service options that may or may not be offered, depending upon the current orientation of the particular PIHP and its provider entities;

- That the resulting waiver aimed at accomplishing these objectives not bring into play so many authorities that its management and implementation is too complicated and unmanageable;

- That Michigan be given the opportunity to fully discuss and explicitly understand the regulatory and policy bases, alluded to or outlined only orally in past discussions, that CMS will apply to ultimately dictate what methods can be used to accomplish Michigan's objectives.

The Michigan Department of Community Health (MDCH) has enjoyed a long-term cooperative relationship with CMS regional and central office staff who has guided the state in its efforts to assure that Michigan's Medicaid beneficiaries with special needs receive the necessary services that enable them to live in the community and realize their full potential. The MDCH Mental Health and Substance Abuse Administration looks forward to continuing to work with CMS as an opportunity to obtain clarification about, and resolution to, the issues listed in the special terms and conditions (STC), and ultimately coming to a long-term resolution that has the greatest positive impact on Michigan residents that is possible.

We sincerely hope that spirit of cooperation can continue as we all work to assure the waiver program is in compliance with federal guidelines at the same time it is meeting our beneficiaries' needs, and look forward to continuing our partnership to serve Michigan's residents. As CMS works to establish bi-weekly conference calls and other discussion forums, please work through Mr. Michael Head, Director of our Mental Health and Substance Abuse Administration, to coordinate and plan these events.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell
Michael J. Head
Irene Kazieczko
Chris Priest

Department 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

May 3, 2010

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

Dear Mr. Fitton:

This letter replaces the letter sent last week also dated May 3, 2010. As previously stated The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that it is approving Michigan's request for a continuation of the Michigan Managed Specialty Services and Supports Program. This waiver is authorized under Sections 1915(b)(1), 1915(b)(3),1915(b)(4), 1902(a)(10)(B) comparability of services and 1902(2)(23) freedom of choice of the Social Security Act. This is a managed care waiver and has been assigned the control # MI-14.R05. While this waiver operates in conjunction with the State's 1915(c) Habilitation Supports waiver, each waiver is considered an independent program that exists on its own merit. Attached you will find the revised terms and conditions to this waiver. This approval is subject to our receipt of your signed acceptance of the revised terms and conditions within 30 days of the receipt of this letter.

The populations served by this waiver cover all categories of Medicaid beneficiaries (children and adults) who require specialty services and supports due to mental disorders, substance use disorders, and developmental disabilities. The approval period for this waiver is one year effective May 1, 2010 through April 30, 2011.

The decision to renew this program for one year is based on information submitted to the Federal Review Team in the application preprint and in response to questions sent to the State throughout the renewal process. The waiver must remain consistent with the Medicaid program and meet all statutory, regulatory and policy requirements for assuring beneficiaries' access to care, receipt of quality services and demonstration of cost effectiveness. The State will need to work with the Federal review team to realign the services funded through 1915(b)(3) authorities and the State plan to ensure the services are provided under the appropriate authorities.

Specifically, the State must agree to the attached Terms and Conditions for this waiver and continue its participation in regular monitoring activities with CMS, including but not limited to bi-weekly calls. As part of these activities the State is expected to provide reports to CMS on the status of its efforts and monitoring of the waiver expenditures for the purpose of compliance with cost-effectiveness. The State will also need to submit any necessary amendments to the waiver or the State plan.

A renewal application for this waiver program should be submitted no later than January 30, 2011. If a waiver renewal is not submitted by that date or the waiver is not in compliance with Federal guidelines, CMS may request a phase-down plan from the State for termination of the waiver program.

Thank you for your cooperation and efforts during the waiver renewal process. We appreciate your staff's commitment to working to provide services and supports to Michigan's Medicaid beneficiaries. We encourage the State to work with CMS in drafting appropriate materials prior to the submission of official documents. If you have any questions please contact Pamela Carson, of my staff, at 312-353-0108 or D. Mark Reed in the CMS Central Office at 410-203-2691.

Sincerely,

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

Enclosure

Terms and Conditions for the Michigan Managed Specialty Services and Supports Section 1915(b) Program, effective May 1, 2010 through April 30, 2011

The Centers for Medicare & Medicaid Services (CMS) is approving Michigan's Managed Specialty Services and Supports Program authorized under Section 1915 of the Social Security Act (the Act) for one year beginning May 1, 2010 through April 30, 2011. This waiver has been assigned the Control No. MI-14.R05.

We are requesting that the State agree to the following special terms and conditions:

1. The State will continue its participation in regular monitoring activities with CMS, including bi-weekly calls.
2. The State will provide reports and updates to CMS on the status of its efforts and monitoring of the waiver expenditures for the purpose of compliance with cost-effectiveness.
3. The State will remove all Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services from under the 1915(b)(3) authority and provide them under the EPSDT section of the State plan. CMS will work with the State to identify the services.
4. The State will work with CMS to identify those services that are currently provided under 1915(b)(3) authority that stand in for State plan services and will move them to fall under "in lieu of" authority.
5. The State will limit the growth of remaining 1915(b)(3) services as instructed in the preprint
6. The State will provide the appropriate statutory authority for the rehabilitative and home and community-based services provided through the waiver.
7. The State will submit any necessary amendments to the waiver or the State plan.

CMS asks that the State sign, date, and return this page to the CMS Regional Office within 30 days indicating that the State accepts the Terms and Conditions.

On behalf of the State of Michigan, I _____
accept the terms and conditions listed above.

_____(print name and title)

_____ (date)

Section 1915(b) Waiver
Proposal for Renewal of Michigan's PIHP Programs for Specialty Services and Supports for FY'10 and FY'11

#MI 14.RO5

April 8, 2010 Amended Waiver Application with the following changes: page 28 "goods and services" eliminated; page 48 "goods and services" eliminated; and a revised Appendix D.

Table of Contents

Proposal

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 Michigan Managed Specialty Services and Supports. (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

_X_ 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: pages 5, 10-13, 26, 46, 67-76, 79, 80, 91, 93, and 112-129 (changes in **bold font and yellow highlight**)

Section B is ___ replaced in full

_X_ 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: **pages 112-118**, changes in **bold font and yellow highlight**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective __**October 1, 2009**_ and ending __**September 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 **Michael Head** and can be reached by telephone at (517) 335-0196, or fax at (517) 335-3090, or e-mail at _**Head@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.

Notification letters regarding the state's plan to submit a renewal application for the Medicaid Specialty Services Waiver and a request for comment were sent to all of the federally recognized tribal chairpersons and health directors on June 1, 2009. The letter invited written comment and offered an opportunity to request discussion via phone or in person. No comments regarding the waiver application were received from Tribal chairpersons or Tribal Health Directors.

The Tribal Health Liaison located in the department's Medical Services Administration participates in quarterly meetings of Tribal Health Directors. These meetings serve as an ongoing forum for the identification and discussion of issues involving the state's Medicaid program. The Tribal Health Liaison shares issues involving the specialty services waiver program and works with staff in the Mental Health and Substance Abuse Administration to resolve issues, clarify information and implement recommendations as needed.

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).

PROGRAM HISTORY

STATE OF MICHIGAN
MANAGED SPECIALTY SERVICES AND SUPPORTS
Mental Health, Substance Abuse and Developmental Disabilities

This renewal requests to continue Michigan's Managed Specialty Services and Supports Waiver program for the period **October 1, 2009 through September 30, 2011**.

BACKGROUND

First Waiver Period:

The Michigan Department of Community Health (MDCH) first received approval for a Medicaid Freedom of Choice Waiver on June 26, 1998. The waiver was authorized under the authority of Sections 1915(b)(1) and 1915(b)(4) of the Social Security Act. The state's request asked for a waiver of Sections 1902(a)(10)(B) and 1902(a)(23) of the Act. It permitted the state to implement a program for Managed Specialty Community Mental Health Services and Supports through Michigan's public, county-based Community Mental Health Services Programs (CMHSPs). Beginning October 1, 1998 CMHSPs became specialty Prepaid Health Plans (PHPs) under contract with the department and received capitated payments to provide necessary services to Medicaid beneficiaries who were eligible for specialty services and supports.

Under the waiver, CMHSPs continued to provide the mental health, substance abuse and developmental disability services and supports that were previously provided under the Medicaid state plan coverages. Or, in lieu of such state plan coverages; CMHSPs were permitted to use their capitation payments to provide more flexible alternative services on an individual basis. Medicaid health care services (physician services, hospital services etc.) are not included in the specialty CMHSP service program, and are provided by a Medicaid-enrolled health care provider. Coordination is required between health care providers and the CMHSPs.

For people with developmental disabilities, the 1915(b) waiver operates in conjunction with Michigan's existing home and Community-Based Habilitation Supports Waiver, authorized under the authority of 1915(c) of the Act. Children with developmental disabilities who are living with their birth or adoptive families who are enrolled in Michigan's Children's Waiver are exempt from the Waiver for Specialty Services and Supports. These children continue to be served by the CMHSPs through the Children's 1915(c) Waiver and other existing fee-for-service Medicaid coverages.

Since its inception, the focus of the Managed Specialty Supports and Services Program has been on quality of care, accessibility, and cost-effectiveness. Waiver purpose, content and direction depend on involvement of consumers, family members and stakeholders. Within this context, MDCH believes that a managed system of supports and services operated through the public mental health and substance abuse systems must be based on values that reflect person-centered planning. This system must support individuals to be:

- Empowered to exercise choice and control over all aspects of their lives;
- Involved in meaningful relationships with family and friends;
- Supported to live with family while children, and independently as adults;
- Engaged in daily activities that are meaningful, such as school, work, social recreation and volunteering; and
- Fully included in community life and activities.

The June 1998 approval letter for the first Medicaid waiver period required that "the State will provide to HCFA no later than two years from the approval date of this waiver, a detailed plan to shift from sole source procurement for its Prepaid Health Plan (PHP) contracts for full and open competitive procurement which comply with the Federal procurement rules at 45 CFR Part 74. This plan must be approved by HCFA as part of the approval process for the first renewal application for this waiver." The approval letter also required that "...within four years of the initial approval of this waiver, all contracts coming up for renewal will be openly and competitively bid..."

Second Waiver Period:

As required, the state submitted a "Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans," in September 2000. The plan was submitted as part of its waiver application for the second waiver renewal period. The plan raised expectations of CMHSPs' performance and included a requirement that PIHPs have at least 20,000 Medicaid beneficiaries in their service areas. CMS approved the renewal application and plan on February 20, 2001 for the period beginning on March 14, 2001 and ending on March 13, 2003.

During the second waiver period, MDCH completed the procurement process to establish Prepaid Inpatient Health Plans (PIHPs) as outlined in its application to CMS. The keystone of the implementation process was the Application for Participation (AFP). Issued on January 3, 2002, the AFP outlined the application process and the required standards for specialty prepaid plans. AFP requirements were:

- Based on values that reflect person-centered planning,
- Included the conditions of the approval in the February 20, 2001 letter from HCFA; and
- Assured that regulations specified in the Balanced Budget Act for Medicaid Managed Care were being met.

Applications submitted by CMHSPs in response to the AFP demonstrated that the CMHSP was able to meet, or had a viable plan with specified dates for completion to meet the standards. In addition, CMHSPs with geographic service areas serving fewer than 20,000 Medicaid beneficiaries formed affiliations to become a PIHP.

As a result of the procurement process, 18 community mental health services programs began serving as PIHPs for Medicaid specialty services and supports on October 1, 2002. Of the 18 PIHPs ten are PIHPs formed by affiliations of CMHSPs and eight are "stand-alone" CMHSPs.

CMS approved three 90-day, temporary extensions of the second waiver period with the last extension allowing for continued operation of the waiver program for the period of September 9, 2003 to December 8, 2003.

Third Waiver Period:

The third waiver renewal application was approved by CMS on December 9, 2003 for the period beginning on October 1, 2003 through September 30, 2005. The approval required significant changes to services and the capitation payment process as follows:

- Previously, the managed specialty services program was regarded as a "combination" 1915(b)/1915(c) program, and capitation payments for the 1915(b) portion of the waiver were combined (in the developmental disabilities capitation) with payments for 1915(c) waiver beneficiaries and services. Under the waiver renewal, however, capitation payments for the 1915(c) Habilitation Supports Waiver were to be made separately from the 1915(b) waiver capitation payments, and exclusively for 1915(c) enrolled beneficiaries who receive a 1915(c) waiver service within the payment month.
- Under prior waiver conditions, capitation payments reflected separate amounts for Medicaid mental health services, developmental disability services and substance abuse services. Under terms of the renewal, payment for Medicaid mental health services and developmental disability services (minus Habilitation Support Waiver reimbursement, were paid monthly in the separate capitation for enrolled beneficiaries) in the 1915(b) waiver were combined in rate calculations and in the monthly capitation payout. Capitation payment for substance abuse services under the 1915(b) waiver continued to be separately calculated and identified.
- Previously, while PIHPs received payments in the 1915(b) portion of the program for Medicaid "state plan" services, they could also use capitation funds to provide – under the authority of section 1915(a)(1)(A) of Title XIX of the Social Security Act – certain other "alternative" services to beneficiaries. Under the waiver renewal, the ability to provide such services remained, but the authority under which these services were provided changed from 1915(a)(1)(A) to 1915(b)(3). Situating these services within the 1915(b) waiver meant that the coverage responsibilities of the PIHP included both state plan and (b)(3) services. All waiver services were then subject to amount, scope, and duration considerations, medical necessity determination, and notice and appeal requirements.

- PIHP payments under the 1915(b) waiver for mental health/developmental disabilities services and for substance abuse services was split between an amount for state plan services and an amount for (b)(3) services.

As in all previous waiver periods, consumers, families and stakeholders continued to be involved in waiver program direction, especially in the identification and definitions for services provided under the authority of 1915(b)(3).

Fourth Waiver Period:

From the period October 1,2005 to September 30, 2006, the program continued to be carried out through contract with the 18 PIHPs as specified in CMS requirements and regulations contained in the Balanced Budget Act for Managed Care. The program continued, based on the values that reflect person-centered planning described above.

Practice improvement was a significant area of focus during this waiver period. The MDCH convened a state-level "Improving Practices Steering Committee" to lead this effort. All 18 PIHPs convened "Improving Practices Leadership Teams (IPLTs)," to oversee implementation of Evidence-Based Practices, Promising Practices, and Emerging Practices by the PIHP. The goal is to offer an improved array of services to adults, and to children and their families. The IPLT from each PIHP links with the state-level committee. All 18 PIHPs began implementing at least one adult evidence-based practice (EBP) (Integrated Treatment for Individuals with Co-occurring Mental Health and Substance Use Disorders or Family Psycho-education). Eleven PIHPs began implementing the Parent Management Training, Oregon model children's EBP. A state-level Developmental Disabilities Practice Improvement Team was convened to examine and recommend policy and program improvements for this population.

Efforts to promote a system of care based in recovery for adults with mental illness were also initiated during the fourth waiver period. The state convened a Recovery Council made up of primary consumer representatives from the IPLTs at all 18 PIHPs, and statewide advocacy and service organizations. The council provides advice on policy and program development for adults with mental illness served in the public mental health system. One hundred and forty peer support specialists participated in a training certification program and are available to assist individuals with mental illness in their recovery journeys.

In response to concerns about slowness or lack of development of opportunities in some communities for competitive jobs, relationships and independent living for persons with developmental disabilities, MDCH established the Developmental Disabilities Practice Improvement Team. Representatives were recruited from CMHSPs, universities, providers and advocacy organizations. The team identified the desired outcomes for people with developmental disabilities, and the opportunities and challenges for achieving the outcomes. The DD PIT is developing a strategy for informing families, providers, CMHSPs, and educators about the possibilities for individuals with developmental disabilities by sharing stories of people's successes, including those with the most profound impairments, who are working in real jobs and living on their own with supports.

A "Fingertip Report" was also developed during this waiver period. Performance information on the 18 PIHPs is published in a series of ten summary tables that include: expenditures of Medicaid funds, service utilization, MDCH site review scores, external quality review scores, adverse events, encounter data, Habilitation Supports Waiver and ICF/MR utilization, reporting timeliness, and Medicaid performance indicators.

Fifth Waiver Period:

During the fifth waiver period, the program as specified in CMS requirements and regulations contained in the Balanced Budget Act for Managed Care. In August 2008, MDCH issued a concept paper that outlined directions for future specialty services and supports program improvements. The paper addressed improving the culture of systems of care, assuring active engagement, supporting maximum consumer choice and control, expanding opportunity for integrated employment, treatment for people in the criminal justice system, assessing needs and managing care, improving the quality of supports and services, developing and maintaining a competent workforce, and achieving administrative efficiencies. The paper was followed by the issuance to PIHPs in February 2009 of an "Application for Renewal and Recommitment" (ARR) that builds on the 2002 Application for Participation (AFP). While the AFP was primarily based on compliance with the Balanced Budget Act and other regulatory requirements, the ARR is based on a quality improvement model for the process of delivering supports and services, the environment in which they are delivered, and their outcomes for Medicaid beneficiaries. In addition the ARR provides clear direction that PIHPs must increase the volume and quality of stakeholder involvement in all aspects of their organizations. PIHPs submitted responses to the ARR June 1, 2009 that described the results of their local "environment scans" on how well they were achieving each of the eleven areas noted above, as well as plans for improvement with milestones and timeframes. By the end of September 2009, nine MDCH teams made up of almost all mental health staff in the Mental Health and Substance Abuse Administration (approximately 40) will have reviewed the responses and provided feedback to the PIHPS. Subsequently, these teams will follow each PIHP over the next several years as they implement their plans for improvement and provide technical assistance and consultation.

MDCH also issued in February a set of "program policy guidelines" (PPGs) to the 46 community mental health services programs. The PPGs also were based on the August concept paper, but focused specifically on building systems of care for children, improving the quality of life for people with developmental disabilities, administering the Recovery Enhancing Environment (REE) instrument with adults with serious mental illness, and increasing access to self-determination and independent facilitation of person-centered planning. CMHSPs submitted requested data on these elements to MDCH where they will serve as baselines from which to measure progress and to PIHPs where they were used in the environmental scans described above.

Two additional initiatives were aimed at improving how providers respond to people who have reputations of challenging behaviors. First, a Technical Requirement for Behavior Treatment Plan Review Committees was attached to the FY'09 MDCH contracts with PIHPs and CMHSPs. In this requirement, MDCH makes clear what kinds of interventions are not allowable in the community as a response to challenging behavior that threatens to harm the individual or another person - seclusion, mechanical restraint, physical management and aversive techniques - and those that are allowed only after review and approval by the Behavior Treatment Plan Review Committee – intrusive and restrictive techniques. The document also contains new data collection, analyses and reporting requirements, and mandates the frequency cycle of Committee review when intrusive and restrictive techniques are used.

The second initiative, Creating a Culture of Gentleness, was aimed at helping providers understand that there are preferred alternative ways to work with individuals who have these reputations, primarily by developing true relationships with them and helping them to feel safe, loved, be loving and be engaged. MDCH sponsored orientation to culture of gentleness sessions conducted by Dr. John McGee that over 460 people attended. These are being followed by regional, more intensive trainings for direct care workers, their supervisors, and case managers to serve people with reputed challenging behaviors. This year also, MDCH established a "safety net plan" to respond to CMHSPs who have exhausted their capacity to respond appropriately to people who exhibit behaviors that threaten their welfare or that of others. The plan builds on the intensive trainings by adding a mobile crisis response, and a temporary crisis placement.

During the fifth waiver period, MDCH continued to emphasize the importance of adopting evidence-based, promising and best practices. Intensive training and coaching in dialectical behavioral therapy, cognitive behavioral therapy, trauma-informed cognitive behavioral therapy, and multi-systemic therapy for juveniles. In addition, several PIHPs were pilot sites for a foundation-funded medication algorithm project. Finally, federal Mental Health Block Grant funds were used to begin pilot projects on developing methodologies for integrating mental health and physical health care. An acknowledged challenge for Michigan's public mental health system is sustaining these preferred practices over the long term.

MDCH continued efforts to support a system of care based in recovery for adults with mental illness so that each person who receives public mental health services is supported in their individual journey of recovery. Key components include:

<u>Certified Peer Support Specialists</u>
MDCH has received state and national recognition for developing a strong and qualified peer-trained work force. Michigan included the covered service option of Peer Support Services as a new element in its 1915(b)(3) additional state plan services, in its fourth waiver renewal period. Peer specialists have a unique background and skill level from their experience in utilizing services and supports.

They have a special ability to gain trust and respect with consumers based on their shared experience. Peers work with consumers in a variety of areas promoting community inclusion, independence and productivity. In August of 2007 the Centers for Medicare and Medicaid issued a letter to all states outlining how peer services can be Medicaid reimbursable with Michigan's waiver as one example. In addition, the letter supported peer services as evidence based practice. To fulfill the requirements of certification, peer specialists attend a comprehensive training program that is conducted by MDCH staff and the Appalachian Consulting Group of Georgia. Upon successful completion of 56 hours of training and a four-hour examination, peers become Certified Peer Support Specialists. As of June 2009, 550 individuals were trained and certified as Certified Peer Support Specialists.

The Michigan Recovery Council and the Recovery Center of Excellence

The Council is made up of 36 representatives 75% of whom are primary consumers. Originally developed as a product of Michigan's Systems Transformation project funded in 2004 under the CMS Real Choice Systems Change grant program, the Council is charged with guiding and overseeing the system transformation to recovery. The Council has been fully engaged, by reviewing current and proposed policies and recommending systems changes including policies and practices that support recovery, promote consumer empowerment, enhance opportunity for consumer self determination, and the growth of the peer support services option. The Council is creating partnerships and networks of consumers and others who will promote a recovery message throughout the system. It supports education, training and technical assistance efforts. Another important component of the CMS System Transformation grant was the creation of the Recovery Center of Excellence (RCE). The vision and mission statement for the Center were developed by the Recovery Council. The RCE uses a virtual organization approach to educate, inform and stimulate statewide dialogue about recovery. The RCE website is: http://www.mirecovery.org/

Recovery Enhancing Environment Measure (REE)

In FY 09 each CMHSP will complete the REE survey within its service area. The REE is a survey of adults with serious mental illness designed to identify the extent to which recovery-enhancing factors are present within mental health programs and the extent to which individuals receiving services report that they are experiencing recovery. The results of the REE will be used to: support a quality improvement process for CMHSPs and MDCH; assist providers, consumers and other stakeholders develop a fundamental understanding of the elements of recovery; strengthen recovery-oriented practices in individual service planning, systems planning and service delivery; and to assess the extent to which recovery-enhancing elements are integrated into current practice. The REE project will provide baseline data to measure progress for future assessments. It will also provide summary data to MDCH and the Recovery Council to support policy development and technical guidance in the oversight of systems transformation.

Sixth Waiver Period

This waiver renewal request for October 1, 2009 to September 30, 2011 continues the program as specified in CMS requirements and regulations contained in the Balanced Budget Act for Managed Care. The program will continue initiatives begun in the previous waiver period as summarized above. In addition, one new initiative described below is planned.

New Initiatives

In the sixth waiver period, MDCH proposes to incorporate self-determination into the specialty services and supports program. Michigan uses the term *self-determination*, rather than the term *self-direction*, to emphasize the value that people use such arrangements to develop and plan a life with activities and supports that are meaningful and appropriate for them. Michigan has a long history of supporting person-centered planning and self-determination, including past discussion with CMS through this waiver application process. At the direction of CMS, Michigan developed a Self-Determination Policy and Practice Guideline and incorporated it into PIHP contracts during the third waiver period. However, the implementation of service and support arrangements that support self-determination has been uneven throughout the state. Incorporating more formally the option to assure access to arrangements that support beneficiary self-determination into this waiver builds upon the availability of the 1915(b)(s) coverage called fiscal intermediary services, which was included in the waiver starting in 2005, and recognizes CMS guidance provided for self-direction as developed under the 1915(c) waiver application process. The follow components will be required for arrangements that support self-determination.

- **Budget and Employer Authority: MDCH will offer participant direction through both budget and employer authority to all waiver participants who live in unlicensed settings. Participation will be voluntary and participants can elect to self-direct one or more of their services and supports.**
- **Individual Budget Development and Monitoring: Each individual budget must be developed through the person-centered planning process and be sufficient to implement each service and support included in the individual plan of service in the amount, scope and duration identified. The fiscal intermediary is responsible for assisting the beneficiary with managing the individual budget and reporting monthly on budget utilization to both the participant and his/her case manager or supports coordinator and/or their independent services and supports broker.**
- **Information and Assistance: The PIHP will furnish information on and assistance with the benefits and obligations of directly managing arrangements that support self-determination to waiver participants through their customer service handbooks, written materials and brochures, "consumer trainings" and through the person-centered planning process. Assistance may also be provided using Peer-Delivered or -Operated Support Services.**

- **Use of a Non-Legal Representative: MDCH allows participants in self-determination to appoint a non-legal representative to direct the arrangements.**
- **Safeguards for Voluntary and Involuntary Termination: Each PIHP must have procedures for both voluntary and involuntary termination of the use of arrangements that support self-determination, including assurance that the person-centered planning process will be utilized to resolve problems and provide assistance prior to invoking involuntary termination.**

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. ___ **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. _X__ **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

___ MCO
_X_ 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.___ **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.

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.___ **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._X_ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
This waiver will operate in conjunction with Michigan's Home and Community Based Habilitation Supports Waiver, Control #0167.90, which is also operated by the PIHPs. That waiver will be in year three of its five-year renewal cycle.

B. Delivery Systems

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

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

b._X__**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.

_X_ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

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

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

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

e. ___ **Fee-for-service (FFS) selective contracting:** 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.___ **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):

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

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

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

1. **Assurances.**

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

___ The State seeks a waiver of section 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):

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
___ Other: (please describe)

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):
The revised Procurement Plan, approved by CMS in February 2001, included rural locations covered by this requested exception.

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

___ 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

___ **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.

County	Type of Program: PIHP	Name of PIHP
Bay, Arenac, Huron,Tuscola, Montcalm, Shiawassee	PIHP	Access Alliance of Michigan
Clare, Gladwin, Isabella, Mecosta, Midland, Osceola	PIHP	CMH for Central Michigan
Clinton, Eaton, Ingham, Gratiot, Ionia, Newaygo, Manistee, Benzie	PIHP	CMH Affiliation of Mid-Michigan
Wayne	PIHP	Detroit-Wayne County CMH Agency
Genesee	PIHP	Genesee County CMH Services
Muskegon, Ottawa	PIHP	Lakeshore Behavioral Health Alliance
Kent	PIHP	Network 180
Jackson, Hillsdale	PIHP	Lifeways
Macomb	PIHP	Macomb County CMH Services
Antrim, Alcona, Alpena, AuSable, Charlevoix, Cheboygan, Emmet, Iosco, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle	PIHP	Northern Affiliation
Crawford, Grand Traverse, Lake, Leelanau, Mason, Missaukee, Oceana, Roscommon, Wexford	PIHP	Northwest CMH Affiliation
Alger, Baraga, Chippewa, Delta, Dickinson, Houghton, Iron, Gogebic, Keewanaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	PIHP	NorthCare
Oakland	PIHP	Oakland County CMH Authority
Saginaw	PIHP	Saginaw County CMH Authority
Lenawee, Livingston, Monroe, Washtenaw	PIHP	CMH Partnership of Southeast Michigan
Allegan, Cass, Kalamazoo, St. Joseph	PIHP	Southwest Affiliation

County	Type of Program: PIHP	Name of PIHP
Lapeer, St. Clair, Sanilac	PIHP	Thumb Alliance PIHP
Barry, Berrien, Branch, Calhoun, Van Buren	PIHP	Venture Behavioral Health

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

_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

___ **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

___ **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:

___**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))
Medicare recipients may voluntarily participate in this Waiver. If they do participate, they may still obtain Medicare covered services from the provider of their choice. Depending upon the beneficiary's particular status (category) as a dually-eligible beneficiary, their co-insurance and deductible for Medicare specialty services will be paid by the responsible PIHP. Medicare recipients who require Medicaid-only specialized services will have their Medicaid-only services provided under this Waiver.

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

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

__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). Medicaid beneficiaries who reside in Nursing Facilities (NF) are included in this waiver; Medicaid beneficiaries residing in ICF/MR are excluded from this waiver.

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

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

_X_ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
Children enrolled in Michigan's Children's Waiver (Waiver #4119.90.R1) are excluded from this Waiver, and will continue to be served by their respective CMHSPs through Medicaid fee-for-service.

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

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

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

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

___**Other** (Please define):

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)

__X__ 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).
1932(b)(2) and 42 CFR 438.11: The PIHP does not cover emergency medical services because those are the responsibility of the Medicaid health care providers. The PIHP covers services to resolve a crisis situation/condition involving the need for mental health, developmental disabilities or substance abuse services.
1905(a)(4) and 42 CFR 431.51(b): The PIHP does not cover family planning services because those are the responsibility of the Medicaid health care providers.

_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.

___ 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.

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

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

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

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.

_X_ 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:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):

__X 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:

___ 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:

___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.

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

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

_X_ 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.

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

1915(b)(3) Service Expenditures FY09

Affiliation DBA	MHB3	SAB3	Total B3	% of Total
Access Alliance of Michigan	21,428,559.46	389,148.00	21,817,707.46	3.81%
CMH Affiliation of Mid-Michigan	29,588,004.70	409,450.81	29,997,455.51	5.23%
CMH for Central Michigan	14,464,911.61	223,481.45	14,688,393.06	2.56%
CMHSA Network of West Michigan	32,164,167.68	582,712.00	32,746,879.68	5.71%
Detroit Wayne County CMH Agency	127,580,051.00	3,344,947.01	130,924,998.01	22.84%
Genesee County CMH Services	31,119,457.01	939,384.09	32,058,841.10	5.59%
Lakeshore Behavioral Health Alliance	20,965,540.60	390,411.29	21,355,951.89	3.73%
Lifeways	10,769,883.39	224,467.77	10,994,351.16	1.92%
Macomb County CMH Services	48,784,520.81	842,829.41	49,627,350.22	8.66%
Northcare	23,507,235.42	257,114.54	23,764,349.96	4.15%
Northern Affiliation	12,404,525.08	276,696.28	12,681,221.36	2.21%
Northern Lakes	14,602,981.76	245,336.83	14,848,318.59	2.59%
Oakland County CMH Authority	67,280,422.86	741,203.40	68,021,626.26	11.86%
Saginaw County CMH Authority	13,270,342.05	365,181.14	13,635,523.19	2.38%
Southeast Partnership	25,875,437.41	420,735.18	26,296,172.59	4.59%
Southwest Alliance	24,913,536.71	487,886.82	25,401,423.53	4.43%
Thumb Mental Health Alliance	20,451,257.46	272,033.23	20,723,290.69	3.61%
Venture Behavioral Health	23,266,220.96	460,816.89	23,727,037.85	4.14%
Grand Total	**562,437,055.97**	**10,873,836.14**	**573,310,892.11**	**100.00%**

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Grand Total	**562,437,055.97**	**10,873,836.14**	**573,310,892.11**	**100.00%**

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

1915(b)(3) Additional Services

Note: proposed changes for the FY'10 and FY'11 Waiver period are highlighted in yellow

1. **Assistive Technology**:

Assistive technology is an item or set of items that enable the individual to increase his or her ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription or Certificate of Medical Necessity as defined in the General Information Section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of the equipment, and warranted upkeep, shall be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle.

- Educational supplies that are required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria for B3 supports and services as well as those in paragraph one for this service. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

2. **Community Living Supports**: are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.).

Coverage includes:

A. Assisting, reminding, observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living such as bathing, eating, dressing, personal hygiene
- shopping for food and other necessities of daily living

CLS services may not supplant state plan services, such as Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). Therefore, if such assistance appears to be needed, the beneficiary, must request Home Help, and if necessary Expanded Home Help, from Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment

B. Staff assistance, support and/or training with such activities as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- socialization and relationship building
- transportation (excluding to and from medical appointments) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence
- participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; voting; etc.)
- attendance at medical appointments
- acquiring or procuring goods other than those listed under shopping, and non-medical services

C. Reminding, observing and/or monitoring of medication administration

D. Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care services in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Department of Human Services (DHS) or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or to guardians of the beneficiaries receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined by the PIHP to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

3.Enhanced Pharmacy: Physician-ordered, nonprescription "medicine chest" items as specified in the person's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.

<u>The following items are covered only for adult beneficiaries living in independent settings (own home, apartment where deed or lease is signed by the beneficiary)</u>:

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth brushes, anti-plac rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices, and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the participant has a diagnosis of dysphagia and either a) a recent history of aspiration pneumonia within the past year or b) documentation that the participant is at risk of insertion of a feeding tube without the thickening agents for safe swallowing

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

4. Environmental Modifications: Physical adaptations to the beneficiary's own home or apartment and/or work place. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his/her pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars
- Widening of doorways
- Modification of bathroom facilities
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his/her environment, and/or ensure health and safety
    - Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary

- Assessments by a appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary or do not support the identified goals of community inclusion and participation, independence or productivity.

- Adaptations or improvements to the home that are of general utility, or cosmetic value and are considered to be standard housing obligations of beneficiary. Examples of exclusions include, but are not limited to carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.

- Cost for construction in a new home or new construction (e.g., additions) in an existing home.

- Environmental modifications costs for improvements exclusively required to meet local building codes

- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, or the Americans with Disabilities Act; or the responsibilities of the Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract and that issues are resolved between all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, and roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a recently purchased existing home.

5. **Crisis Observation Care:** This program, that must be pre-approved by MDCH (see Section 1.4 on Programs Requiring Special Approval), is a hospital-based service, less than 24 hours in duration, involving rapid diagnosis, treatment and stabilization of an individual with a psychiatric or substance abuse emergency, and that results in sufficient amelioration of the situation to allow the person to be discharged and transferred to an outpatient care service.

   Standards and criteria for Crisis Observation Care are as follows:

   - Services must be provided in a secure, protected, medically staffed, psychiatrically supervised inpatient unit that included an on-site or on-call physician and must meet the requirements of the Mental Health Code, Chapter 4 and 4a. The utilization of this 1915(b)(3) additional service may be justified for persons who, as a result of a psychiatric disorder (including co-occurring substance disorder), are deemed likely to need protective, psychiatric observation and supervision for the purpose of additional evaluation and stabilization of a mental disorder prior to determination of an alternative disposition or movement to a different, clinically-appropriate level of care (per Michigan Mental Health Code, Section 134).
   - Services must not be provided in an emergency room, screening center, inpatient medical floor, or inpatient medical observation bed.
   - The primary objective of this level of care is for prompt evaluation and/or stabilization of individuals presenting with acute psychiatric symptoms and distress. Before or at

admission, a comprehensive assessment is conducted and a treatment plan is developed.

- The individual who is admitted to the Crisis Observation Care has the same rights (as defined in Chapter 7 of the Michigan Mental Health Code and other applicable state and federal laws) as an individual who is admitted to the Inpatient Psychiatric Unit.
- The medical record must document that the individual was under the care of a psychiatrist during the period of observation (as indicated by admission, discharge and other appropriate progress notes that are timed, written and signed by the physician).
- The duration of services at this level of care must be less than 24 hours, by which time stabilization and/or determination of the appropriate level of care will be made, with facilitation of appropriate treatment and support linkages by the treatment team.

Formal MDCH approval is not required for this service; however, MDCH should be notified (through the service agency profile) that this service is being utilized by the PIHP, prior to providing this service.

6. Family Support and Training:

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his/her ability to achieve goals of a) performing activities of daily living; b) perceiving, controlling, or communicating with the environment in which he/she lives; or c) improving his or her inclusion and participation in the community or productive activity, or opportunities for independent living. The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

<u>Coverage includes these models</u>:

- Education and training including instructions about treatment regimens, and use of assistive technology and/or medical equipment that are needed to safely maintain the person at home specified in the individual plan of service.
- Counseling and peer support provided by trained peers one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-parent Support is designed to support parent/families of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their children to improve in functioning. The trained parent support partner, who has

or had a child with special mental health needs, provides education, training, and support, and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

- **(NEW) Counseling and peer support provided by trained youth peer support specialists, one-on-one or in a group, for individuals with serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. This service provides support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and need help in navigating the public human services system.**

7. **Fiscal Intermediary Services**: Service that assists the adult beneficiary, or a representative identified in the beneficiary's plan, to meet beneficiary's goals of community participation and integration, independence or productivity while controlling his/her individual budget and choosing staff who will provide the services and supports identified in the individual plan of service and authorized by the PIHP. The fiscal intermediary helps the individual manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to, the facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting; tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures; assuring adherence to federal and state laws and regulations; and ensuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications, including reference and background checks and assisting the individual to understand billing and documentation requirements.

   Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained I the person's plan of services so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

   Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other function and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, the

family members, nor guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

8. **Housing Assistance**: Assistance with short-term, interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements, while in the process of securing other benefits (e.g. SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance;

Additional criteria for using Housing Assistance:

- The beneficiary must have in his/her individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his/her living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI, or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness.
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his/her own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits
- Home maintenance that is of general utility, or cosmetic, and are considered to be standard housing obligations of the beneficiary

Replacement or repairs of appliances should follow the general rules under Assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (see general rules under Environmental Modifications). Replacement or repairs of appliances, and repairs to the home or apartment do not need a prescription or order from a physician.

9. Peer-Delivered or -Operated Support Services: Programs and services that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

Peer Specialist Service

Peer support services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experience and perspectives with disabilities and with planning and negotiating human services systems.

- Vocational assistance: seeking educational and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment)
- Housing assistance: locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs of room and board utilizing an individual budget; purchasing a home, etc. (reported as supports coordination*)
- Services and Supports Planning and Utilization Assistance: assistance and partnership in the person-centered planning process (reported as either treatment planning or supports coordination*); developing and applying arrangements that support self-determination; assistance with directly selecting, employing or directing support staff; sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy; accessing entitlements; developing wellness plans; developing advance directives; learning about and pursuing alternatives to guardianship; providing supportive services during crises; developing, implementing and providing ongoing guidance for advocacy and support groups. Activities provided by peers are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence and productivity.

Qualifications: Individuals providing Peer Support Services must be able to demonstrate their experiences in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those generally recognized and accepted to be peers. Persons utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. Individuals who are functioning as Peer Support Specialists serving

persons with mental illness must meet MDCH specialized training and-certification requirements.

*Peer case managers, supports coordinators or supports specialists must be trained; and supervised by a PIHP or CMHSP case manager or supports coordinator who meets the qualifications of case manager or supports coordinator. Peer counselors must be trained, and supervised by a qualified mental health therapist

Drop-in Centers: Peer-Run Drop-In centers provide an informal, supportive environment to assist individuals with mental illness in the recovery process. If an individual chooses to participate in Peer-Run Drop-In Center services, such services may be included in an individual plan of services if medically necessary for the person. Peer-run Drop-In Centers provide opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

Program Approval: PIHPs must seek approval from MDCH prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:

a. Staff and board of directors of the center is 100% primary consumers
b. PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program
c. PIHP facilitates consumers' ability to handle the finances of the program
d. The drop-in center is at a non-CMH site
e. The drop-in center has applied for incorporation as a 501(c)(3) non-profit entity
f. There is a contract between the drop-in center and PIHP, or its subcontractor, identifying the roles and responsibilities of each party
g. There is a liaison appointed by the PIHP to work with the program

Documentation: Individual plan of service identifies goals and how the program supports those goals; and the amount, scope and duration of the services to be delivered. Individual clinical record provides evidence that the services were delivered consistent with the plan.

9. **Prevention-Direct Service Models**: Programs using individual, family and group interventions designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. One or more of the following direct prevention models must be made available by the PIHPs or their provider network: Children of Adults with Mental Illness/Integrated Services, Infant Mental Health when not enrolled as a Home-Based program, Parent Education, Child Care Expulsion Prevention, and School Success Programs.

Coverage includes:

a. Child Care Expulsion Prevention (CCEP)

CCEP provides consultation to childcare providers and parents who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings. Sometimes these challenges may put children at risk of expulsion from the childcare setting. CCEP aims to reduce expulsion and increase the number of families and childcare providers who successfully nurture the social and emotional development of children 0-5 in licensed childcare programs.

CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes:

- Observation and functional assessment at home and at child care
- Individualized plan of service developed by team
- Intervention (e.g., coaching and support for parents and providers to learn new ways to interact with child, providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis.)

Provider qualifications:
Master's prepared early childhood mental health professional (licensed master's social worker, psychologist, licensed professional counselor) who is trained in mental health interventions. Effective 10/01/09, training requirements must minimally have Endorsement Level 2 by the Michigan Association of Infant Mental Health; Level 3 is preferred**.**

b. School Success Program works with parents so that they can be more involved in their child's life, monitor and supervise their child's behaviors; works with youth to develop pro-social behaviors, coping mechanisms, and problem solving skills; and consults with teachers in order to assist them in developing relationships with these students. Mental Health staff also act as a liaison between home and school.

Provider qualifications: Child Mental Health Professional

c. Children of Adults with Mental Illness/Integrated Services are designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the public mental health system and to improve outcomes for adult clients who are parents. The Integrated Services approach includes assessment and service planning for the adult beneficiaries related to their parenting role and their children's needs. Treatment objectives, services and supports are incorporated into the service plan through a person-centered planning process for the adult recipient who is a parent. Linking the adult recipient and child to available community services, respite care and providing for crisis planning are essential components.

Provider qualifications: Mental Health Professional

d. Infant Mental Health provides home-based parent-infant support and intervention services to families where the parent's condition and life circumstances or the

characteristics of the infant threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder. PIHPs or their provider networks may provide infant mental health services as a specific service when it is not part of a Department certified home-based program.

Provider qualifications

Master's prepared early childhood mental health professional (licensed master's social worker, psychologist, licensed professional counselor) who is trained in mental health interventions. Effective 10/01/09, training requirements must minimally have Endorsement Level 2 by the Michigan Association of Infant Mental Health; Level 3 is preferred.

e. Parent Education is provided to parents using evaluated models that promote nurturing parenting attitudes and skills, teach developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development and to remediate problem behaviors.

Provider qualifications:

Child mental health professional that is trained in the model.

10. **Respite Care Services:** Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid primary care giver (family members and/or family foster care providers) and is provided during those portions of the day when the caregivers are not being paid to provide care. Respite is not intended to be provided on a continuous, long-term basis where it is part of the daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

    Respite care may be provided in the following settings:

    a. Beneficiary's home or place of residence
    b. Licensed family foster care home
    c. Facility approved by the State that is not a private residence, such as:
        i. Group home; or
        ii. Licensed respite care facility
    d. Home of a friend or relative chosen by the beneficiary and members of the planning team
    e. Licensed camp
    f. In community (social/recreational) settings with a respite worker trained, if needed, by the family

Respite care may not be provided in:

- day program settings
- ICF/MR, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- individual's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

12. Skill-Building Assistance: consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his/her economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the participant's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change.

Coverage includes:

a. Out-of-home adaptive skills training:

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including

- Aides helping the beneficiary with his/her mobility, transferring, and personal hygiene functions at the various sties where adaptive skills training is provided in the community.
- When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings

b. Work preparatory services

Services aimed at preparing a beneficiary for paid or unpaid employment, but that are not job task-oriented. They include teaching such concepts as attendance, task completion, problem

solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are primarily directed at reaching habilitative goals, such as improving attention span and motor skills, not at teaching specific job skills. These services must be reflected in the person's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

c. Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

Service that would otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (P.L. 94-142).

13.Support and Service Coordination: Functions performed by a supports coordinator, coordinator assistant, supports and services broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

a. Planning and/or facilitating planning using person-centered principles
b. Developing an individual plan of service using the person-centered planning process
c. Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
d. Brokering of providers of services/supports
e. Assistance with access to entitlements, and/or legal representation
f. Coordination with the Medicaid Health plan, Medicaid fee-for-service, or other health care providers.

The role of supports coordinator assistants is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case management, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager is described in Section 13 – Targeted Case Management in this Chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then, to make the necessary arrangement to link the beneficiary with those supports (item d. above). The role of

the supports coordinator or supports coordinator assistant, when a services and supports broker is used, is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports are performed.

Whenever independent supports and service brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager or their assistants employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has a supports coordinator or coordinator assistant, AND a services and supports broker for function d. above, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the state will review individual plans of service to verify that there is not duplication of service provision when both a supports coordinator assistant and a service and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators will work closely with the beneficiary to assure his/her ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as a face-to-face contact with the beneficiary, however the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored

- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages, and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

Qualifications of support coordinators: A minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.

Qualifications of support coordinator assistants, and supports and service brokers: minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent supports and service brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

14. **Supported/Integrated Employment Services**: Provide job development, initial and ongoing support services and activities as identified in the individual plan of services that assist persons obtain and maintain paid employment that would be otherwise unachievable without such supports. Support services are provided continuously, intermittently or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.

    Coverage includes:

    - Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.

    - Consumer-run businesses (e.g. vocational components of Fairweather Lodges, supported self-employment) Transportation provided from the beneficiary's place of residence to the site of the supported employment

service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA); or through Michigan Rehabilitation Services.

15. Wraparound Services for Children and Adolescents

Wraparound services for children and adolescents is a highly individualized planning process performed by specialized supports coordinators who coordinate the planning for and delivery of Wraparound services, and incidental non-staff items that are medically necessary for the child beneficiary. The planning process identifies strengths, needs, strategies (staffed services and non-staff items) and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, and informal supports. The Child and Family Team creates a highly individualized plan of service for the child beneficiary that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, or B3 services. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community. The wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child beneficiary and family and is developed in partnership with other community agencies. This planning process tends to work more effectively with child beneficiaries who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound.
Child beneficiaries served in wraparound shall meet two or more of the following:

- Children who are involved in multiple systems
- Children who are at risk of out-of-home placements or are currently in out-of-home placement
- Children who have been served through other mental health services with minimal improvement
- The risk factors exceed capacity for traditional community-based options
- Numerous providers are serving multiple children in a family and the outcomes are not being met.

Note: Wraparound planning and service coordination is reported as Wraparound Facilitation (H2021); and items and services purchased with non-Medicaid funds are reported as Wraparound (H2022) in the encounter data system. Children receiving Wraparound may not also receive at the same time the Supports Coordination coverage or the state plan coverage Targeted Case Management.

Section 18: ADDITIONAL SUBSTANCE ABUSE SERVICES (B3s)

Certain Medicaid-funded substance abuse services may be provided in addition to the Medicaid State Plan Specialty Supports and Services through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). These B3 substance abuse services are to be provided to eligible beneficiaries who both reside in the PIHP's region and request the services**.** The B3 services may be purchased with the Medicaid capitation or with Medicaid savings as described in the MDCH/PIHP contract. Medicaid funds may not be used to pay for room and board for B3 services.

The PIHP may provide these services only when the service:

- Meets medical necessity criteria for the beneficiary (See MDCH/PIHP Contract Attachment P.3.2.1, Medical Necessity Criteria); and
- Is based on individualized determination of need; and
- IS cost effective; and
- Does not preclude the provision of a necessary state plan service; and
- Meets a level of care (LOC) determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria

1. Sub-Acute Detoxification

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization and fostering client readiness for and entry into treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Patient Placement Criteria an individualized determination of client need.

The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Patient Placement Criteria:

Outpatient Setting:

Ambulatory Detoxification -- without extended onsite monitoring corresponding to ASAM Level I-D or ambulatory detoxification with extended onsite monitoring: (ASAM Level II-D)

Outpatient setting sub-acute detoxification must be provided under the supervision of a Certified Addictions Counselor. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level II-D ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses

Residential Setting:

Clinically Managed Residential Detoxification -- Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D) These services must be provided under the supervision of a certified addictions counselor. Services must have arrangements for access to licensed medical personnel as needed.

- Medically Managed Residential Detoxification: Freestanding detoxification center. These services must be staffed 24-hours per day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician. (ASAM Level III.7-D)

This service is limited to stabilization of the medical effects of the withdrawal and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization Requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current client status, which provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.

- Admission to Sub-Acute Detoxification must be made based on:

    - Medical Necessity Criteria
    - LOC determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria.

- Initial length-of-stay authorizations may be for up to three days with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.–

2. Residential Treatment

Residential Treatment is defined as intensive therapeutic service, which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program and treatment is provided by appropriate credentialed professional staff including substance abuse specialists. Residential treatment must be staffed 24 hours per day.–

This **i**ntensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that intensive outpatient and outpatient treatment have not been effective or cannot be safely provided and when the beneficiary provides evidence of willingness to participate in treatment.

- Admissions to Residential Treatment must be based on:

  - Medical Necessity Criteria
  - LOC determination based on an evaluation of the 6 assessment dimensions of the current ASAM Patient Placement Criteria

- The PIHP may authorize up to 22 days of treatment.

- Additional days may be authorized when authorization requirements continue to be met and if there is evidence of progress in achieving treatment plan goals and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

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. ___ **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. ___ **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. ___ **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. ___ **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			
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. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
This Waiver covers all categories of Medicaid beneficiaries (children and adults) who required specialty services and supports due to serious mental health needs, substance disorders, and/or developmental disabilities. Eligibility criteria (diagnostic, functional, impairments, level of service need, and medical necessity) for specialty services are defined in state Medicaid policy and/or state statute.

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

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by

the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

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:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
The individual plan of service is developed in a person-centered planning process that involves the participation of the beneficiary as well as a representative of the PIHP.

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. ___ **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.

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 June 23, 1998,, and revisions subsequently approved by CMS in 2000, 2003, 2005 and 2007. A revised Quality Strategy is in Attachment A.III.1

_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
PIHP	**Health Services Advisory**	**Compliance with all managed**	*Validation of Performance Measures	None

	Group	**care standards**	*Validation of Performance Improvement Projects	

2. **Assurances For PAHP program.**

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

___ The State seeks a waiver of 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.

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

b. ___ **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. ___ **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. ___ **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:

Attachment A.III.1

STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED SPECIALTY SERVICES AND SUPPORTS
Revision 6/30/09

[**Note: Revisions are noted in bold type and are highlighted in yellow**]

The following strategy is designed to assess and improve the quality of specialty services and supports managed by the Prepaid Inpatient Health Plans (PIHPs). The state agency responsibility for the components of the quality management system listed here resides in the Michigan Department of Community Health (MDCH), Division of Quality Management and Planning, except where otherwise noted.

I. BACKGROUND: PROCESS FOR QUALITY STRATEGY REVIEW AND REVISION

This quality strategy builds upon and improves the initial strategy developed for the 1915(b)(c) waiver application in 1997, and revised for each subsequent waiver renewal application. As with the previous quality strategies, this quality strategy was developed with the input of consumers, and the Mental Health Quality Improvement Council (QIC) that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Boards. This revised and improved strategy also reflects the activities, concerns, input or recommendations from the MDCH Encounter Data Integrity Team, the **External Quality Review** (EQR) **activities**, and the **recommendations for improvement** from the Centers for Medicare and Medicaid Services (CMS) **2007** waiver approval.

II. CERTIFICATION, ACCREDITATION, AND LICENSURE

A. Community Mental Health Services Program Certification**:** The approved Plan for Procurement and the subsequent Application for Participation (2002) (AFP) required that each PIHP be a community mental health services program (CMHSP). The Michigan Mental Health Code (Code) requires that every CMHSP be certified by MDCH) in order to receive funds. The certification consists of two elements:

1. Each CMHSP must be determined to have a local recipient rights system that is in substantial compliance with the requirements of the Recipient Rights Chapter 7 of the Code. This compliance is determined by on-site visitation by the MDCH Office of Recipient Rights.
2. Each CMHSP must be in compliance with a set of organizational standards established in Michigan's Administrative Rules, which have the effect of law. The rules cover the following dimensions: Governance, mission statement, community education, improvement of program quality, personnel and resource management,

physical/therapeutic environment, fiscal management, consumer information, education and rights, eligibility and initial screening, waiting lists, alternative services, array of services, medication, and individual plan of service.

It is required that the CMHSP and each of its subcontracting providers of mental health services meet these standards. If a CMHSP or its sub-contracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said accreditation. MDCH has granted deemed status to four national accrediting bodies: Joint Commission on Accreditation of Health Care Organizations (JCAHO), CARF, The Council on Accreditation (COA), and The Council. Certification may be granted for up to three years. CMHSPs must be certified prior to entering into a prepaid contract for services and supports for beneficiaries.

In order to screen children for inpatient hospitalization or out-of-home placement, CMHSPs must meet the Children's Diagnostic and Treatment Services Programs (CDTSP) certification requirements. CDTSPs are assessed and re-certified every three years.

B. Provider Networks:

1. CMHSPs as "Affiliates" and other providers: Affiliates and sub-contracting providers must meet the certification requirements stated in A above.

2. Substance Abuse Coordinating Agencies and Providers: PIHPs may subcontract with Substance Abuse Coordinating Agencies (CAs) to manage the substance abuse treatment benefit. **Eight** PIHPs are currently CAs. CAs are not licensed or accredited for ongoing treatment services, but all of their subcontracting providers of outpatient, residential, intensive outpatient, sub-acuter residential and methadone substance abuse services are required to be licensed under the Michigan Public Health Code. CAs must be appropriately licensed if operating their own central diagnostic and referral service. In addition, state and federal funds administered by MDCH for treatment services may be contracted only with licensed providers accredited by one of the following national accrediting bodies: JCAHO, CARF, COA, National Council on Quality Assurance (NCQA) and the American Osteopathic Association (AOA). Licensing actions are the responsibility of the MDCH, Bureau of Health Systems, who consults with the CAs and the Mental Health and Substance Abuse Administration (MH&SA) and shares with, and consults on**,** all licensing findings to the administration.

   Persons seeking substance abuse treatment must be assessed by a professional and authorized for treatment. [Please see provider qualifications in the Medicaid Provider Manual] In completing the assessment, the American Society for Addiction Medicine (ASAM) Patient Placement Criteria must be

applied to determine the appropriate level of treatment. These criteria are also employed for continuing stay and discharge decisions by the treatment and/or assessment program.

3. Certification and Licensing for Settings Where Services are Provided:
    a. Specialized Mental Health Residential Certification: All adult residential service providers who receive funds for the provision of specialized mental health services must be certified by the Michigan Department of Human Services (MDHS). These standards address issues such as: accessibility, facility environment, fire safety, and staffing levels and qualifications. Specifically, these rules require that all staff who work independently and who function as lead workers must complete training which covers eight areas, including the role of residential care workers, introduction to the special needs of adults with developmental disabilities and mental illness, basic interventions for maintaining and caring for a recipient's health, basic first aid and CPR, medications, environmental emergencies, recipient rights, and non-aversive techniques for preventing or managing challenging behaviors. While these rules do not require a schedule of re-training, PIHPs will be required to assure that these staff be re-trained whenever the treatment needs of the resident(s) change and whenever there is a significant change in MDCH policy which would affect the delivery of services. In addition, PIHPs are required, as part of the CMHSP certification, to have a local process to assure that persons providing services and supports are competent to perform their duties.

    b. Adult Foster Care Licensing**:** The MDHS also acts as the licensing agent for Adult Foster Care settings. Formal mechanisms of communication exist between MDHS and MDCH to share information regarding the findings from the respective settings. For example, licensing problems identified by MDHS are forwarded to MDCH for follow-up as part of its contractual or site visit processes. PIHPs, in turn, and/or their subcontracting provider networks, have the responsibility to report potential problems to the MDHS for follow-up.

    c. Protective Services: MDHS also has responsibility for Adult and Child Protective Services. PIHPs, along with their subcontracting provider networks, have a legal responsibility to report potential violations to the local MDHS offices.

4. Coordination On Issues Involving Adult Foster Care Settings
    a. Staff from the MDCH MH & SA Administration meet as needed with MDHS central office staff to share information, jointly revise policies, and trouble-shoot on various issues including self-determination, individuals' own homes, state plan home help services, critical incidents and sentinel events.

III. AFP AND CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

Three areas addressed by the BBA and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the CMS-approved Quality Assessment and Performance Improvement Programs. These elements were required as part of the AFP, are now part of the MDCH/PIHP contracts, and they are reviewed by MDCH staff and/or the EQR organization.

A. **Customer Services**

Customer services is required by the MDCH/PIHP contract to be an identifiable function of the PIHP that operates to enhance the relationship with the community, as well as with the beneficiary. Customer services is frequently a function delegated by the PIHP to affiliates or providers, including the substance abuse network. When delegated, the PIHP must monitor the entity to which the function is delegated**.** In 2006, MDCH developed Customer Services Standards and standard language for their Customer Services handbooks. The Standards and handbook language were included in the FY2007 MDCH/PIHP contract and are located on MDCH's web site at www.michigan.gov/MDCH, click on Mental Health and Substance Abuse, then Mental Health and Developmental Disabilities, then Customer Services. In addition, MDCH provided training to 110 customer services representatives in September 2006.

MDCH has reviewed and approved each of the PIHP's customer services handbooks and requires the PIHPs to resubmit the handbooks for review and approval anytime a substantive change is made.

PIHPs found out of compliance with these standards by the External Quality Review must submit plans of correction. MDCH staff and the EQRO follow up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH MH & SA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

. B. **Appeals and Grievances Mechanisms**

CMS approved the BBA revision of the appeals and grievance procedures, required by MDCH/PIHP contract. The EQR reviews the process **for providing** information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its ~~Appeals~~ **Fair Hearings** database to

track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH MH&SA Management Team and with the QIC). Information is used by MDCH to take contract action as needed, or by the QIC to make recommendations for system improvements.

C. **Quality Assessment and Performance Improvement Programs**

The MDCH contracts with PIHPs require that the QAPIP be developed and implemented. **There are planned changes for the QAPIP for the coming waiver period (see Attachment A.III.1.a)** The EQR monitors on-site the PIHPs' implementation of their local QAPIP plans that must include the 14 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: VIII Sentinel Events, **IX Behavior Treatment Review** and XI Credentialing of providers. MDCH collects data for Standard VI, Performance Indicators, VII Performance Improvement Projects, and XII Medicaid Services Verification, as described below.

1.Performance Indicators

Please see section VI.A of this Quality Strategy.

2. Performance Improvement Projects

The MH & SA Management Team, the QIC, and Division of Quality Management and Planning staff collaborate to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, EQR findings, and stakeholder concerns.

For the upcoming waiver period Michigan will require all PIHPs to conduct a minimum of two performance improvement projects:

a. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH as identified above. In the case of PIHPs with affiliates, the project is affiliation-wide.
b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, may be assigned a specific project topic relevant to the problem. At the present time, PIHPs were allowed to choose a second performance improvement project in consultation with their QAPIP governing body.

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

3. Medicaid Services Verification

PIHPs are required to develop and maintain a system for verifying that Medicaid-funded services identified in the plan of service were actually rendered. PIHPs submitted their plans for the Medicaid verification system to MDCH for initial approval in 2001 and are periodically asked to resubmit their methodologies. PIHPs report to MDCH annually on the results of their Medicaid verification systems.

4.Credentialing Policy

The External Quality Review Organization, Health Services Advisory Group, recommended that MDCH develop a state level credentialing policy. That was done and attached to the FY 2007 amendment to the MDCH/PIHP contract. The policy is in Attachment A.III.1.b

IV. EXTERNAL QUALITY REVIEW

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the EQR for an additional **three** years, beginning **October 2008**. HSAG worked with MDCH and representatives from the PIHPs to **develop** review protocols for Michigan. **The BBA compliance monitoring portion of the** EQR consists of desk audits of PIHP documents and **also includes either** a two-day on-site visit **or telephone conference with each PIHP. The decision to conduct an on-site review versus a telephone conference is based on past PIHP performance on the EQR BBA compliance monitoring reviews.**

The contents of the review for **FY 08-09** are:

a. Validation of Performance improvement projects:
   i. For FY08-09, the EQR focused on the methods PIHPs **initially** employed to implement the MDCH-required project –**Improving the Penetration Rates for Children. The PIP validation process included reviews of the following activities:**
      1. **Choosing the study topic**
      2. **Defining the study questions**
      3. **Selecting the study indicators**
      4. **Using a representative and generalized study population**
      5. **Using sound sampling methods**
      6. **Using valid and reliable data collection procedures**
      7. **Including improvement strategies and implementing interventions**
      8. **Describing data analysis and interpreting study results**
   ii. **In FY 09-10 the PIP validation process will also evaluate the following PIP activities:**
      1. **Reporting improvement**
      2. **Describing sustained improvement**
b. Validation of performance indicators:

i. **For FY08-09 EQR looked at data collection methods for all twelve performance indicators and performed an ISCAT.**

ii. **EQR reviewed the results for each indicator and noted areas for improvement and areas of strength for each PIHP.**

c. Compliance with Michigan's Quality Standards per BBA:

i. **In FY 08-09 the EQR focused on reviewing compliance with the following standards:**

1. **QAPIP and Structure**
2. **Performance measurement and improvement**
3. **Practice guidelines**
4. **Staff qualification and training**
5. **Utilization management**
6. **Customer services**
7. **Recipient grievance process**
8. **Recipient rights and protections**
9. **Subcontracts and delegation**
10. **Provider networks**
11. **Access and availability**
12. **Coordination of care and care management**
13. **Psychiatric advanced directives**
14. **Service authorization and appeals**
15. **Credentialing**

ii. **In FY 09-10, the EQR will focus on following up on any problems identified in the FY 08-09 review cycle.**
In FY10-11, MDCH intends to have the EQR conduct an optional activity as described in 42 CFR438.358(c).

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

V. MDCH ON-SITE REVIEW OF PIHPS**:**

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

A. <u>Clinical Record Review</u>

Reviews of clinical records to determine that 1) person-centered planning is being utilized; **2) access to and information about independent facilitation of person-centered planning is made available; 3) access to, information about, and supports for self-determination, including individual budgets, is made available;** 4) health and welfare concerns are being addressed if

indicated; 5) services identified in the plan of service are being delivered; and 6) delivery of service meet program requirements that are published in the Medicaid Provider Manual. Random samples of clinical records to be reviewed are drawn by the MDCH review. Limited advanced notice is provided to PIHPs about the records selected for review. An additional set of randomly selected records is requested without advance notice after the team has arrived on-site. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs, all affiliates (if applicable), a sample of providers, and an over-sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

B. Administrative Review

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

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

C. Consumer/Stakeholder Meetings

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

D. Consumer Interviews

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

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

Overall PIHP site review responsibility is located in the Division of Quality Management and Planning. The PIHP site review team is **currently** composed of a minimum of **seven** MDCH staff: two registered **master's degreed** nurses, a licensed master's social worker, **two analysts**, and two individuals who have a mental illness and meet the qualifications for, and are employed as, analysts. The Division of Substance Abuse and Gambling Services provides additional staff to conduct the portion of the review that focuses on the PIHP's Medicaid Substance Abuse treatment program. The Office of Mental Health Services to Children and Families provides additional staff to conduct the portion of the review that focused on the Children's Waiver (Home and Community Based Waiver).

VI. DATA SUBMISSION AND ANALYSES

A. Performance Indicators

Medicaid performance indicators measure certain aspects of performance of the PIHPs. The specific Medicaid performance indicators (listed in Attachment A.III.1.c) have been extracted from the more comprehensive Michigan Mission-Based Performance Indicator System that has evolved since 1997 based on adoption of core indicators by national organizations or federal agencies (e.g., Center for Mental Health Services and Center for Substance Abuse Treatment). The performance indicators were revised in 2005 by the QIC. The indicators are categorized by domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to suggest that there are trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in the MDCH data warehouse. Any data that are submitted by PIHPs, and the methodologies for doing so, are validated by MDCH and the EQR. Analyses of the data result in comparisons among PIHPs and with statewide averages. Statistical outliers are determined for the identification of best practices or conversely, opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, leading up to PIHP contract action. Technical information from the performance

indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements**.**

B. Encounter and Quality Improvement Data

Demographic characteristics as well as summary encounter data have been reported to MDCH annually for each mental health service recipient since the early 1990s. Individual level demographic data and admission and discharge records for persons receiving substance abuse treatment services have been collected by MDCH since 1980. Beginning in FY'03, individual level encounter data were reported electronically in HIPAA-compliant format each month for all services provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data were also reported monthly for each individual. Data are stored in the MDCH data warehouse where Medicaid Health Plan and Pharmacy encounter data are also stored. MDCH MH&SA staff with access rights to the warehouse analyze mental health, substance abuse, pharmacy and health plan data to evaluate appropriateness of care, over- and under-utilization of services, access to care for special populations, and the use of state plan service versus 1915(b)(3) services.

Aggregate data from the encounter data system are shared with MDCH MH&SA Management Team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

C. Medicaid Utilization and Net Cost Data

PIHPs are required by contract to submit Medicaid Utilization and Net Cost Reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PIHP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH MH&SA Management Team, the EDIT, with the State's actuary, and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

D. Sentinel Events

Sentinel events involving persons who receive Targeted Case Management, or are enrolled in the Habilitation Supports Waiver, or live

in 24-hour specialized residential settings, or live in their own homes receiving ongoing and continued personal care or **community living supports** services are reported, reviewed, investigated and acted upon at the local level by each PIHP or its delegated agent. This information is reported in the aggregate to the MDCH **quarterly**. Sentinel events include, but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, **emergency physical management interventions used for controlling** serious challenging behaviors and medication errors.

Michigan law and rules require the mandatory reporting of the issues above to the Adult Foster Care Licensing Division of MDHS within 48 hours for persons in licensed residential settings, and to the CMHSPs' Office of Recipient Rights for all others. There is specific language in law to establish the duty to report to law enforcement suspected abuse and neglect. The reporting of sentinel events is the primary responsibility of residential workers for persons in licensed settings, and case managers or supports coordinators for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to PIHPs.

Aggregate data are shared with MDCH MH&SA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

E. Recipient Rights

Local CMHSP offices of recipient rights report semi-annually summaries of numbers of allegations received, number investigated, number in which there was an intervention, and the numbers that were substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state Office of Recipient Rights and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH MH&SA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

F. Service Agency Profiles

CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years and to update in the interim any changes to providers: addition of new providers, termination of contracts, change in accreditation status, change of address. This information is kept in a database and is used by the MH&SA Administration to verify the capacity of the service network.

G. Cost Allocation Reports

Section 460 of Michigan Public Act 330 of 2006 mandates that MDCH develop a uniform methodology for PIHPs to allocate and report service and administrative costs. Beginning in 2007, PIHPs began reporting their direct service and administrative costs as well as those of their prime subcontractors according to the newly developed methodology with a six-month report due each June 30th, and an annual report due each January 31st. In addition, a cost allocation plan is due each September 30th. The cost allocation reporting requirements may be found at www.michigan.gov click on Mental Health and Substance Abuse, then Reporting Requirements.

VII. FINGER TIP REPORTS

Performance information on the 18 PIHPs is published in a series of ten summary tables that include: expenditures of Medicaid funds, service utilization, MDCH site review scores, external quality review scores, adverse events, encounter data, Habilitation Supports Waiver and ICF/MR utilization, reporting timeliness, and Medicaid performance indicators. The information is used internally by MDCH for follow-up and decision-making; and is available for public review on the MDCH web site at www.michigan.gov/mdch click on Mental Health and Substance Abuse, the Mental Health and Developmental Disabilities, then Statistics and Reports.

VIII. STATE WIDE SURVEY

The Michigan Legislature's Appropriations Act for MDCH requires that an annual survey of consumer satisfaction be conducted. Since 1998 the Michigan Department of Community Health (MDCH) has commissioned an annual statewide consumer satisfaction survey of adults with mental illness using the Mental Health Statistics Improvement Program (MHSIP) 28-item questionnaire. Consumers were randomly sampled from the pool of consumers who had received services during the previous year.

In order to enhance the use of statewide satisfaction results at the state and local level, a new approach to the evaluation of consumer satisfaction was implemented in 2007. During April 2007, each PIHP was asked to oversee and conduct the 28-item MHSIP on a smaller scale among all of their Assertive Community Treatment programs. In addition, PIHPs were also asked to conduct the 26-item version of the MHSIP Youth Services Survey for Families consumer satisfaction surveys among children receiving services in home-based care. The Mental Health Quality

Improvement Council has elected to use this approach for the spring of FY2008 as well as FY2009. The QIC made one modification to this approach. Beginning in FY2008, the new MHSIP 44-item Consumer Survey was employed for adults with mental illness, for the first time in Michigan. This instrument includes the additional domains of satisfaction with functioning and social connectedness, as well as information on arrest history.

IX. MENTAL HEALTH SYSTEMS TRANSFORMATION

a. The Mental Health and Substance Abuse Administration began its systems transformation initiative in the spring of 2004 in response to the President's New Freedom Initiative, and to Michigan's Mental Health Commission Recommendations. The Administration promotes the development or enhancements of local PIHP and subcontractor organizational cultures that adopt evidence-based practices (EBPs), best practices and promising practices **and that evaluate and continuously improve existing practices.**

b. **A steering committee of Administration staff, mental health consumers, and representatives from the PIHPs, major state universities, and mental health advocacy organizations oversees the implementation of the practices and makes recommendations to MDCH on how federal Mental Health Block Grant funds should be dispersed to support and sustain these efforts. To-date, the Mental Health Block Grant funds have supported the adoption of Family Psycho-Education (FPE), Integrated Dual Diagnosis Treatment for Co-Occurring Disorders (IDDT), Parent Management Training/Oregon Model, multi-systemic therapy (MST) for youth, dialectical behavioral treatment, and cognitive behavioral therapy. The steering committee also advises on how the outcomes of the practices should be measured, and how fidelity to the models will be monitored.**

c. The Administration convenes a group of developmental disabilities advocates and clinicians to plan improvements and strategies for implementing them in services and supports for persons with developmental disabilities. Training and technical assistance to PIHPs and their providers is the focus of the team's work.

X. PHARMACY QUALITY IMPROVEMENT PROJECT

MDCH is in its **fifth year** of a grant from the Eli Lilly Corporation to implement a pharmacy quality improvement project. Comprehensive NeuroScience (CNS) is analyzing pharmacy claims for Medicaid beneficiaries who use psychotropic medications to review prescribing practices of physicians and patient adherence to prescriptions. The outcomes of the project are to improve continuity of care, eliminate redundant treatments, coordinate care among providers, and decrease risks associated with inappropriate use. Prescribing physicians have access to peer psychiatrists for consultation about improved practices. **Results from the**

project so far, indicate reduction in poly-pharmacy and in costs of behavioral health care medications.

XI. CONTRACT COMPLIANCE REVIEW AND ACTION

The controlling document to assure that quality mental health and substance abuse services will be maintained is the contract between the MDCH and the PIHPs. The contract includes specific language regarding issues of general compliance, the compliance review process, and the dispute resolution process. Specific language allows for emergency reviews by MDCH whenever there is an allegation of fiscal impropriety, or endangerment of health and safety of beneficiaries. The contracts make clear that MDCH may utilize a variety of remedies and sanctions, ranging from the issuance of a corrective action plan to withholding payment to contract cancellation.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS
July 2009

[Note: Proposed revisions for FY'10-11 are in bold]
The State require**s** that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002.This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.

II. The QAPIP must be accountable to the Governing Body - Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.
B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.
C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

III There is a designated senior official responsible for the QAPIP implementation.

IV There is active participation of providers and consumers in the QAPIP.

V The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

A. PIHP must utilize performance measures established by the department in

the areas of access, efficiency and outcome and report data to the state as established in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department **(see Attachment A.III.1.c)** and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.
   1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.
   2. Non-clinical areas would include, but not be limited to, appeals, grievances and complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. The statewide project for FY'09 and FY'10 is improving the access to services for children who are Medicaid beneficiaries and adult beneficiaries with substance use disorders as measured by the performance targets individually negotiated between MDCH and each PIHP. Future state-directed projects will be selected by MDCH with consultation from the Mental Health Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII The QAPIP describes the process of the review and follow-up of sentinel events.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate, with root cause analyses to commence within two business days of the sentinel event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.
***"Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect**.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Only techniques that have been approved during person-centered planning by the beneficiary or his/her guardian, and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.
B. As a result of the assessments, the organization:
    a. Takes specific action on individual cases as appropriate;

b. Identifies and investigates sources of dissatisfaction;

c. Outlines systemic action steps to follow-up on the findings; and
d. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDCH and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.

The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDCH's Credentialing and Re-credentialing Processes, January 2007, Attachment A.III.1.b, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

a. Educational background
b. Relevant work experience
c. Cultural competence
d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable**),** providers and subcontractors.

A. The PIHP must submit to the state for approval its methodology for verification.
B. The PIHP must submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under utilization as well as over utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
3. The reasons for decisions are clearly documented and available to the member.
4. There are well-publicized and readily-available appeals mechanisms for both providers and patients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

Department of Community Health
Mental Health and Substance Abuse Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES
January 2007

A. Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid billable or reimbursable. PIHPS are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider Manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

Note: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. MDCH recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis, while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:

    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants
    c. Psychologists (Licensed, Limited License, and Temporary License)
    d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians

e. Licensed Professional Counselors
f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
g. Occupational Therapists and Occupational Therapist Assistants
h. Physical Therapists and Physical Therapist Assistants
i. Speech Pathologists

2. The PIHP must ensure:

a. The credentialing and re-credentialing processes do not discriminate against:

(1) A health care professional, solely on the basis of license, registration or certification; or

(2) A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the Michigan Department of Community Health website at www.michigan.gov/mdch. (Click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHP's policies and procedures. Compliance will be assessed based on the PIHP's policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHP's written credentialing policy must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP’s governing body, and

a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;

b. Describe any use of participating providers in making credentialing decisions;

c.Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;

d. Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program are incorporated into the re-credentialing process.

6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:

a. The initial credentialing and all subsequent re-credentialing applications;

b. Information gained through primary source verification; and

c. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

1. A written application that is completed, signed and dated by the provider and attests to the following elements:
   a. Lack of present illegal drug use.
   b. Any history of loss of license and/or felony convictions.
   c. Any history of loss or limitation of privileges or disciplinary action.
   d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:

a. Licensure or certification.
b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
c. Documentation of graduation from an accredited school.
d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:

(1) Minimum five-year history of professional liability claims resulting in a judgment or settlement;
(2) Disciplinary status with regulatory board or agency; and
(3) Medicare/Medicaid sanctions.

e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

D. Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed 150 days.

The PIHP shall have up to 31 days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.

2. History of loss of license, registration, or certification and/or felony convictions.

3. History of loss or limitation of privileges or disciplinary action.

4. A summary of the provider's work history for the prior five years.

5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:

1. Licensure or certification;

2. Board certification, if applicable, or the highest level of credential attained; and

3. Medicare/Medicaid sanctions.

The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.

2. An update of information obtained during the initial credentialing.

3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
a. Medicare/Medicaid sanctions.
b. State sanctions or limitations on licensure, registration or certification.
c. Member concerns which include grievances (complaints) and appeals information.
d. PIHP Quality issues.

F. Credentialing Organizational Providers

For organizational providers included in its network:

1. Each PIHP must validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.

2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-

credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDCH's credentialing process).

G. Deemed Status

Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.

H. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision

Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements

The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., DCH, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the DCH Medicaid Managed Specialty Supports and Services Contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB) The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers are entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHP is a Prepaid Inpatient Health Plan under contract with the Department of Community Health to provide managed behavioral health services to Medicaid eligible individuals.

Provider is any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

MEDICAID SPECIALTY SUPPORTS AND SERVICES
PERFORMANCE INDICATORS FOR PIHPS
Revised for Fiscal Year 2010

1. The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95% in three hours

2. The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95% in 14 days

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. Standard = 95% in 14 days

4.a. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. Standard = 95%

4.b. The percent of discharges from a substance abuse detoxification unit who are seen for follow-up care within seven days. Standard = 95%

4. *The percent of Medicaid recipients having received PIHP managed services.

5. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month other than supports coordination.

6. *The percent of total expenditures spent on managed care administrative functions for CMHSP and PIHPs.

7. *The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who are in competitive employment.

8. *The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSPs and PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop).

9. The percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

10. The annual number of substantiated recipient rights complaints per thousand persons served, in the categories of Abuse I and II, and Neglect I and II.

11. The semi-annual number of sentinel events per thousand Medicaid beneficiaries served (MI adults, MI children, persons with DD, HSW enrollees, Children's Waiver enrollees, and SA).

12. The percent of adults with developmental disabilities served, and the percent of adults with serious mental illness served, who live in a private residence alone, with spouse or non-relative(s).

13. The percent of children with developmental disabilities who receive at least one service each month other than case management/supports coordination and respite.

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.

___ 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.
Each PIHP is contractually obligated to serve all eligible beneficiaries in its catchment area who need specialty services and is required to make public information available to their citizenry concerning the services they

provide. The information they provide is not for the purpose of attracting additional "enrollees," but is intended to acquaint beneficiaries with the availability of services. In 2006, MDCH developed standards for customer services handbooks that **became** effective October 1, 2007. The customer services standards and handbook template can be found on the MDCH web site at www.michigan.gov/mdch, click on Mental Health and Substance Abuse, then Mental Health and Developmental Disabilities, then Customer Services**. MDCH required each PIHP to submit their Customer Services handbook for review and approval. PIHPs are also required to submit proposed revisions to MDCH for review and approval.**

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.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3._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.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii._X Other (please explain):

Since the 2003 Waiver renewal, the PIHPs have been contractually required to follow the federal guidance concerning "Persons with Limited English Proficiency." Specifically this includes:

Where an eligible LEP language group constitutes 10% or 3,000, whichever is less, of the population of persons eligible to be served, the entity provides written materials including vital documents in that language. Where the language group constitutes 5% or 1,000, whichever is less, the entity ensures that, at a minimum, vital documents are translated into the language. Translation of other documents can be oral. Where the language group constitutes fewer than 100 persons, the entity should provide written notice in the primary language of the group, of the right to receive competent oral translation of written materials. Each PIHP is contractually obligated to serve all eligible beneficiaries in their catchment area who need specialty services and are required to make public information available to their citizenry concerning the services they provide. The information they provide is not for the purpose of attracting additional "enrollees," but is intended to acquaint beneficiaries with the availability of services. PIHP informational documents that are made available to the public are subject to MDCH review during its regular site visits to PIHPs.

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.

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

3._X Other (please explain):
Since the 2003 Waiver renewal, the PIHPs have been contractually required to follow the federal guidance concerning "Persons with Limited English Proficiency." Specifically this includes:

_____ Where an eligible LEP language group constitutes 10% or 3,000, whichever is less, of the population of persons eligible to be served, the entity provides written materials including vital documents in that language. Where the language group constitutes 5% or 1,000, whichever is less, the entity ensures that, at a minimum, vital documents are translated into the language. Translation of other documents can be oral. Where the language group constitutes fewer than 100 persons, the entity should provide written notice in the primary language of the group, of the right to receive competent oral translation of written materials. Each PIHP is contractually obligated to serve all eligible beneficiaries in their catchment area who need specialty services and are required to make public information available to their citizenry concerning the services they provide. The information they provide is not for the purpose of attracting additional "enrollees," but is intended to acquaint beneficiaries with the availability of services. PIHP informational documents that are made available to the public are subject to MDCH review during its regular site visits to PIHPs.

_X__ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.
Accommodations, including oral translation, are contractually required to be available through customer services at each PIHP.

_X__ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.
The State mails a brochure annually to each Medicaid beneficiary, and each new enrollee, that describes the specialty mental health services. In addition, the brochure is posted on the MDCH web site. Effective October 1, 2007, all PIHPs **were required to** use standard language in their customer services handbooks.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X__ State
___ contractor (please specify) _____

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

c. Enrollee Information

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

(i) _X_ the State

(ii) ___ State contractor (please specify):_____

(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

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

___ The State seeks a waiver of 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:
The State mails a brochure annually to each Medicaid beneficiary, and each new enrollee, that describes the specialty mental health services. In addition, the brochure is posted on the MDCH web site.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

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

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

Broker name: _____

Please list the functions that the contractor will perform:
___ choice counseling
___ enrollment
___ other (please describe):

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

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. ___ Potential enrollees will have____days/month(s) to choose a plan.
ii. ___ 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 State **automatically enrolls** beneficiaries
___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the

beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

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

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

___ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.
While Medicaid beneficiaries are considered mandatorily-enrolled in the PIHP that serves their county of residence, the beneficiaries voluntarily seek PIHP services when they determine they have a need (unless court-ordered on an involuntary basis). Beneficiaries, who need the specialty services that are provided under this Waiver, and who meet clinical eligibility criteria, must request through a telephone call or walk in, the services from the specialty PIHPs.

d. **Disenrollment:**

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

i.___ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause

reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

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

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

i. ___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

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

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

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

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

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.

___ 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 60 days.

c. **Special Needs**

_X_ The State has special processes in place for persons with special needs. Please describe.

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

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

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

___ The grievance procedures 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 non-procurement 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 excluded 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												
Accreditation for Participation				√								
Consumer Self-Report data	√		√		√	√	√					√
Data Analysis (non-claims)						√	√	√	√			
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network												

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
Adequacy Assurance by Plan												
Ombudsman												
On-Site Review	√	√	√	√	√	√		√	√	√	√	√
Performance Improvement Projects							√		√			
Performance Measures							√		√			√
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization												

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
Review												
Other: (describe)												
MDCH Review and Approval of Customer Services Handbooks					√							
EQR 2004				√	√					√		√
EQR 2005							√		√		√	
EQR 2006				√	√			√				
EQR 2007-08	√	√								√	√	
EQR 2008-09	√	√		√	√	√	√		√	√	√	√
EQR 2009-10 (follow-up review of completion of plans of correction)	√	√		√	√	√	√		√	√	√	√
Application for	√	√	√	√	√	√	√	√	√	√	√	√

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
Participation 2002												
Service Agency Profiles								√			√	
Application for Renewal & Recommitment 2009	√								√			√

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. ____ 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)

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

Each PIHP must be a **MDCH-certified CMHSP or be comprised of an affiliation of MDCH certified CMHSPs** certified according to Section 330.1232a of the Michigan Mental Health Code. This certification process is triennial and is conducted by MDCH staff. The protocol was provided as part of the response to the 2005 pre-renewal CMS information request. **Portions** of the certification process may be waived if the PIHP is accredited by JCAHO, CARF, or COA.

c. __X__ Consumer Self-Report data

___ CAHPS (please identify which one(s))

___ State-developed survey

___ Disenrollment survey

___ Consumer/beneficiary focus groups

_X_ Other: 1. SAMHSA's Mental Health Statistical Improvement Program consumer satisfaction survey is used annually **by PIHPs for a total enumeration of adult beneficiaries with serious mental illness and families of child beneficiaries with serious emotional disturbance receiving services from two MDCH-selected programs during spring of the fiscal year.**

2. MDCH site review staff conduct face-to-face **or telephone** interviews **with** Medicaid beneficiaries about the Specialty Services program **during the full reviews of the PIHPs. During the past two year review cycle, MDCH site review staff members interviewed nearly 2000 individuals who were receiving services from the PIHPs.**

d. __X__ Data Analysis (non-claims)

_X_ Denials of referral requests

Annually, MDCH collects from CMHSPs data on the number of Medicaid beneficiaries who requested services and of those who were accepted or denied, and of those denied, who were referred to the Medicaid Health Plans or elsewhere.

___ Disenrollment requests by enrollee

___ From plan

___ From PCP within plan

_X_ Grievances and appeals data

The data on beneficiary requests for Fair Hearing and their disposition are collected from the Administrative Tribunal which conducts the Medicaid Fair Hearings. **T**he Division of Quality Management and Planning **collects and analyzes these requests** by program type (1915 b and c), population (mental health, developmental disabilities, and substance abuse) and PIHP. PIHPs are **also** required to keep logs of beneficiary grievances and their dispositions and make the logs available to MDCH site reviewers annually.

___ PCP termination rates and reasons

_X_ Other (please describe)

Sentinel events: PIHPs report **quarterly** on the numbers of sentinel events that occurred during the period for beneficiaries living in Specialized Residential settings, or who receive Targeted Case Management **or support coordination**, or who live on their own and receive daily and continuous assistance for activities of daily living. Results of the reports are published in rates per thousand persons served.

Timely access: PIHPs report quarterly on three performance indicators that address the timeliness of access: 1) from initial request for non-emergent service to face-to-face assessment with a professional (95% must occur within 14 days); 2) from assessment to first service (95% must occur within 14 days); and 3) from presenting in a crisis situation to disposition of whether to admit to inpatient services (95% within 3 hours). PIHPs are contractually required to meet the standards.
Medicaid Utilization and Net Cost Reports: PIHPs submit an annual report that summarizes the cases, units and costs for the Medicaid specialty services and supports program. The report is used to validate the encounter data, and to monitor the Medicaid managed care service and administrative costs.
Cost Allocation Reports: PIHPs submit an annual report that summarizes the expenditures for direct services and for administrative functions according to a standard methodology directed by MDCH. The report contains the direct service and administrative costs for the PIHPs prime subcontractors as well.

e. _____ Enrollee Hotlines operated by State

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

g. _____ Geographic mapping of provider network

h. _____ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

i. _____ Measurement of any disparities by racial or ethnic groups

j. __X__ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

k. _____ Ombudsman

l. __X__ On-site review

The PIHPs receive a full review or a follow-up review in alternating years. The full review consists of a review by a MDCH team of clinicians, analysts and consumers using a site review protocol. This

review consists of a review of administrative policies and procedures, discussions with PIHP administrative staff, clinical record reviews of a sample of beneficiaries, and interviews with a sample of beneficiaries using a standardized questionnaire. The review results in a report issued to the PIHP and a requirement that the PIHP submit a corrective action plan for any noted report findings. This corrective action plan is reviewed and approved by MDCH and a follow up review is conducted the following year. The follow-up review verifies that the plan of correction was implemented and that it achieved the desired results.

m. __X__ Performance Improvement projects [**Required** for MCO/PIHP]

___ Clinical

_X__ Non-clinical

Two projects per waiver period are required of the PIHPs. One project during the past waiver period was mandatory for all PIHPs **to** improve the timeliness of access to the first service following an assessment by a professional of a newly-enrolled beneficiary. **The required study topic for FY08-09 is improving the penetration rates for children. PIHPs were allowed to choose the topic for their second performance improvement project.** Reports on the progress of the projects are submitted to MDCH semi-annually **and the mandated study topic is also reviewed by the EQRO as part of the PIP validation process.**

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

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

PIHPs submitted data to MDCH for eight performance indicators during the waiver period. Information is analyzed by MDCH staff and issued in reports back to the PIHPs and to Mental Health and Substance Abuse Administration management team. Contract action is taken for failure to meet standards in two consecutive quarters, or for being a negative statistical outlier for two consecutive quarters.

o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____Profile utilization by provider caseload (looking for outliers)

q. ____Provider Self-report data

___ Survey of providers

___ Focus groups

r. _____ Test 24 hours/7 days a week PCP availability

s. _____ Utilization review (e.g. ER, non-authorized specialist requests)

t. __X___Other: (please describe)

a. External quality review. **External Quality Reviews (EQRs) began assessing PIHP performance for the October 2003-September 2004 time period. Annual EQRs have been conducted since that time. MDCH's External Quality Review Organization, Health Services Advisory Group (HSAG) continues to conduct annual EQR activities that assess PIHP compliance with BBA requirements, as well as validating Performance Improvement Projects and Performance Indicators. HSAG's review activities include on-site reviews, analysis of submitted materials, and telephone conferences with the PIHPs.**

b. The 2002 Application for Participation (AFP) covered all aspects of the BBA relative to PIHPs. Applicant CMHSPs provided documents and assurances that they would comply with the standards. Subsequent site visits from MDCH staff verified their assurances. The AFP responses from the PIHPs awarded a contract became part of those contracts to which the PIHPs have been held accountable since 2002. MDCH site review teams and the EQR have performed subsequent reviews of the BBA standards compliance.

c. Service agency profiles are collected by MDCH on all providers of covered Medicaid services and are updated at least triennially, or before that if changes have been made in providers (additions, terminations, change of address, etc.). The information is maintained in a data base maintained by the Division of Quality Management and Planning. The services agency profiles provide information about Medicaid services provided, and accreditation status.

Section C: Monitoring Results

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:

Strategy:

Accreditation for Participation

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of Results
Each of the eighteen PIHPs are composed of single or multiple CMHSPs that are currently certified in accordance with Section 330.1232a of the Michigan Mental Health Code.
Problems Identified
No systemic problems or issues were identified during the state's certification activities.
Corrective Action
N/A
Program Change
N/A

Strategy: Consumer Self-report
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
1.Summary of Results of Consumer Interviews Conducted by MDCH Staff
The site review team conducted **almost 2,000** interviews with consumers and/or family members during the **October 2007-September 2009 review cycle. Four more reviews are scheduled to be completed before September 30, 2009.** The information obtained from these interviews is used in two different ways in the site review reporting process: 1) where possible, it is used in the scoring process in making the determination as to whether the PIHP is in full, partial or non-compliance with established review protocol standards; and 2) written narrative summaries of the information are provided to the PIHP for informational purposes.

The issues identified in the consumer interviews **generally** corroborate findings noted in clinical record reviews. **Interviews continue to demonstrate a very high degree of satisfaction with services and supports. Interviewed individuals confirm that essential elements of person-centered planning are occurring and that their health and safety concerns are being addressed in service planning and delivery.**
Problems Identified
No systemic problems have been identified through the interview process.
Corrective Action (plan/provider level)
To the extent any of the feedback received from consumers can be used to reflect PIHP performance on state site review standards, it is included in the formal written report and the PIHPs must identify how they will correct the findings in the remedial action plan they submit to the state. The effectiveness of the corrective actions taken in response to the feedback will be assessed as part of the follow-up site review process.

2.Summary of Results of Statewide Survey of Beneficiaries

During May 2008, each PIHP was required to conduct the MHSIP satisfaction survey for all adults in their Assertive Community Treatment programs. In addition, PIHPs were also required to conduct the MHSIP YSS-F Consumer Satisfaction Survey among children receiving services in home-based care. This is only the second year that MDCH has implemented the YSS-F. For 2008, the percentage of adult consumers in agreement ranged from 89.6% for satisfaction with Quality to 75.1% for satisfaction with Outcomes and 73.5% for satisfaction with Social-Connectedness. The percentage of families in agreement ranged from 96.9% for satisfaction with Cultural Sensitivity of staff to 56.9% for satisfaction with Outcomes.

Problems identified

Survey results for most items have remained at 85 percent or above for most items in the MHSIP and the YSS-F. However, the average percentage in agreement for the outcomes domain has stayed in the 70 percent range for adults and in upper 50 percent range for children.

Corrective action (plan/provider level)

The PIHPs will continue to use the information from the MHSIP and YSS-F surveys in order to focus improvements at the local and program levels.

Program change (system-wide level)

Based on a recommendation from the Quality Improvement Council, in 2007 MDCH changed the strategy for collecting consumer satisfaction data in order to get information specific for each PIHP.

Data analysis

Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain:

1. Denials of Referral Requests Data

Summary of Results

MDCH**'s** Program Policy Guidelines (PPG) identify the specific types of Medicaid beneficiaries who were denied access to specialty services. This information includes tracking the number of individuals who telephoned or walked in for screening, the number accepted as clients, the number denied eligibility, the number who were denied eligibility and referred to a Medicaid Health Plan, Medicaid fee for service provider, or referred elsewhere, the number

denied eligibility and not referred elsewhere, and the number or telephone calls or walk in requests that were about non-mental health related services, i.e., food stamps. This information is collected by population, including Medicaid eligible adults with SMI, Medicaid eligible children with SED, Medicaid eligible adults with a developmental disability, and Medicaid eligible children with a developmental disability.

A summary of the **2008** data received using this methodology showed that approximately **80%** of Medicaid eligible beneficiaries who telephoned in, or walked in for a screening, were determined to be eligible for services. **Slightly less than 11%** of those who telephoned or walked in requested help with non-mental health related services. Nearly all of the individuals denied eligibility was given referrals to other providers, including Medicaid Health Plans, Medicaid Fee for Service Providers, or other providers. Less than 1 percent of those who were denied eligibility for services were not referred elsewhere for assistance.

Problems Identified

None.

Program Change

None.

2.Grievances and Appeals Data

Summary of Results

The overall number of requests for Fair Hearings in FY 07-08 was 324.

Problems Identified

No systemic problems have been identified through data analysis. Only a small number of the Fair Hearing requests actually result in a formal hearing decision. The overwhelming majority of the requests is settled before getting to a hearing or is dismissed at the hearing. In Fiscal Year **07-08**, only **64 of the 324** Fair Hearing requests actually resulted in a formal hearing. Of those **64**, the PIHP's decision was upheld **54** times and decisions in favor of the beneficiary occurred ~~14~~ **10** times. **Thirty-nine of the Fair Hearing Requests were dismissed due to the beneficiaries' failure to appear, 18 were dismissed due to lack of jurisdiction, and 166 were dismissed because the issue was resolved or the beneficiary withdrew their request.**

Corrective action

To date, no PIHP has been required to submit any corrective action plan because of low or high numbers of requests for Fair Hearings. MDCH Quality Management staff also review each one of the Fair Hearing requests submitted. They follow up with the PIHPs when there are questions concerning the health and welfare of an individual who has filed a fair hearing request.

Program change

None

3. Sentinel Events Data

Summary of Results

MDCH staff collect and monitor sentinel event data for specific populations served by the PIHPs. MDCH Quality Management staff members follow up when sentinel events are reported to help ensure statewide consistency in data collection and reporting. In addition, nurses from MDCH's site review staff review and evaluate each PIHP's sentinel event reporting and root cause analysis process as part of the site review activities.

Problems Identified

No systemic problems have been found in terms of provision of care with regards to sentinel events. Discriminating between critical incidents and sentinel events is sometimes problematic for PIHP staff members. As a result they sometimes report higher numbers of sentinel events than would be expected.

MDCH staff follow-up with those PIHPs whose rate of sentinel events exceed expectation and provide technical assistance to PIHP staff on determining which critical incidents meet the criteria for sentinel event reporting. MDCH site review staff members have identified isolated issues concerning PIHP sentinel event root cause analysis processes and have included these findings in the PIHP site review reports.

Corrective action

To the extent any sentinel event related findings are identified as part of the site review process, the PIHP is required to submit a formal corrective action. This corrective action is reviewed and approved by MDCH site review staff members. These same staff members follow up on subsequent site visits to ensure that the corrective actions have been implemented.

4.Timely Access

Summary of Results

For FY'08 the annual average mean score on the first timeliness performance indicator - time between presentation for inpatient screening to disposition regarding inpatient admission (standard is 95.0% of disposition occur within three hours) - showed annual average mean scores of 97.17% for adults and 98.80% for children. On the second indicator, time between first request and initial assessment (standard is 95.0% within fourteen days), the average annual score was 98.07% for all populations combined. The state-wide average was above the 95% standard for all populations with mean scores of 97.99% for SED children, 98.43% for adults with mental illness, and 97.98% for children with a developmental disability, 96.98% for adults with a developmental disability, and 97.91% for individuals with a substance abuse disorder. On the third timeliness indicator, time between assessment and first service (standard is 95% within fourteen days), annual average mean was 96.96%. The standard was met for all of the populations

with an average score of 95.50% for SED children, 96.68% for adults with mental illness, 95.98% for children with a developmental disability, 95.47% for adults with a developmental disability, and 98.74% for individuals with a substance abuse disorder.

Problems identified

For the first indicator noted above, one PIHP did not meet the 95% standard for the adult population during any of the four quarters for FY08 (Detroit-Wayne).

On the second indicator, 14 days between first request for service and assessment, the annual average for two PIHPs did not meet the standard for SED children (Detroit-Wayne and Northwest). Detroit Wayne also did not meet the standard for this indicator for adults with mental illness, children with a developmental disability or adults with a developmental disability. Two PIHPs (Lakeshore Affiliation and Thumb Alliance) did not meet the standard for indicator #2 for the consumers with a substance abuse disorder.

For the third indicator, the annual average score for four PIHPs did not meet the 95% standard for children with serious emotional distress (Access Alliance, Detroit-Wayne, network180 and Saginaw) and three PIHPs did not meet the standard for adults with mental illness (Detroit-Wayne, network180, Saginaw). Six PIHPs did not meet the standard for children with a developmental disability (Access Alliance, Detroit/Wayne, Macomb, North Care, Saginaw, Venture) and seven PIHPs did not meet the standard for adults with a developmental disability (Detroit/Wayne, Macomb, network180, North Care, Northwest, Saginaw, Venture). Seventeen of the PIHPs meet the standard for consumers with a substance abuse disorder (Detroit-Wayne did not meet the standard).

Corrective action

Based on results from the Performance Indicators, MDCH will follow up with contract performance objectives for FY'10.

Program Change

Strategy: Network adequacy

Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain:

Summary of Results

Through the 2002 Application for Participation (AFP) process, the state reviewed the 18 PIHPs' provider network configuration, selection and management. PIHPs were also required to attest to meeting the standards therein, submit supportive

documentation, and provide verification of the attestation during AFP site reviews from the state. The requirements in the PIHP contracts governing the provider networks are contained in the MDCH/PIHP contract. Continuing compliance, including recruitment and retention of direct provider panel networks, is monitored through the site review process and the central registration of all providers. This is also an area monitored as part of the EQR process.

Problems Identified

A few non-systemic problems with network adequacy have been identified through site review activities. There have been isolated problems with PIHPs not having a particular program required as part of the continuum of services. In addition, there have been some site review and External Quality Review findings concerning shortcomings in the PIHP's formal provider network monitoring processes.

Corrective Action

The PIHPs must address any findings noted as part of the site review or external quality review processes in formal corrective action plans that are reviewed and approved by MDCH. In addition, the PIHP's implementation of the corrective actions plan, and the effectiveness of the corrective action plan in achieving desired results are monitored as part of the continuing site review and external quality review processes.

Program Change

None

Strategy: On-site review

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of Results

During the October 2007-September 2009 Waiver period, the MDCH site review team conducted full and follow-up reviews on each of the 18 PIHPs. At the present time, full reviews have been conducted on 14 PIHPs, with full reviews on the remaining four PIHPs scheduled to take place before the end of September 30, 2009. The site review process includes reviews of administrative policies and procedures, discussions with PIHP administrative and provider staff members, reviews of clinical records, and interviews with consumers and/or family members. Thus far in the October 2007-September 2009 Waiver period, the MDCH site review team has reviewed nearly 2,800 clinical records for compliance with a standard set of protocols and interviewed almost 2,000 consumers and/or family members.

Problems Identified

MDCH continues to publish a summary of PIHP site review performance **on Table C of the Fingertip Report. Overall PIHP site review performance has continued to improve with each review cycle.** Although there were no

discernable system-wide problems found consistently at each PIHP for specific individual review dimensions, there were overall subject areas where many of the PIHP's failed to achieve full compliance. These included the areas of person-centered planning and plan of service documentation, administrative requirements (provider monitoring, quality improvement, and health and safety), and record documentation requirements.

Corrective action

MDCH requires the PIHPs to submit corrective action plans that address any review dimension findings of partial or non-compliance. Each PIHP was required to submit a remedial action plan in response to MDCH site review activities. MDCH follow-up on identified findings included monitoring of the PIHPs' plans of correction to assure implementation; technical assistance training for PIHP and subcontractor staff and program directors; as well as on-site consultation. In addition to the actions undertaken by Quality Management and Planning staff members, other DCH staff members provided technical assistance and additional monitoring on Home-Based, Assertive Community Treatment, Psycho-Social Rehabilitation and other programs. As needed, these staff members provided additional on-site visits, technical assistance and monitoring to ensure that appropriate corrective actions were developed and implemented.

Program change

None

Strategy: Performance Improvement Projects

Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain

Summary of Results

Each PIHP is required to implement a minimum of two performance improvement projects (PIP) during the Waiver Period. During the October 2007 to September 2009 time period, the PIHPs have completed one set of two PIPs and begun implementing a second set in January 2009. The first set of projects was described in the previous waiver renewal application and the MDCH-mandated PIP topic primarily involved improving the timeliness of access to care. Final reports on those projects were submitted in July 2008.

In January 2009 the PIHPs submitted the first reports on a second set of PIPs. The MDCH-mandated PIP topic was Improving the Penetration Rates for Children and the PIHPs were allowed to choose the topic for the second required PIP. The MDCH mandated PIP was also reviewed by Health Services Advisory Group (HSAG) as part of the external quality review PIP validation process. HSAG's PIP validation process included reviews of the following activities: choosing the study topic, defining the study questions, selecting the study indicators, using a representative and generalized study

population, u**sing valid and reliable data collection procedures**, i**ncluding improvement strategies and implementing interventions**, and d**escribing data analysis and interpreting study results**

Problems Identified

A review of the submitted reports, as well as EQR validation activities on PIP #1 **in 2008 demonstrated maintained** improvement in the design, implementation, and outcomes of these PIPs. In **2008** EQR validation assessments, preliminary reports validated 13 PIHP's PIPs, **4** were partially met, and **1 was** not validated. This performance was improved from the previous year where **13** PIHP's PIPs were validated, **3** were partially validated, and **4 2** were not validated. **Some of the problems identified with the PIP validation processes involved data collection methodologies and statistical analyses on performance improvement project outcomes.**

Corrective action

During the waiver period, the State's EQR provider conducted technical assistance training for the PIHPs in the area of Performance Improvement Project design and implementation. In addition, those PIHPs whose projects were not validated will have to develop and implement corrective actions in response to the findings identified in the EQR performance improvement project validation reports.

Program change

None.

Strategy: Performance Measures

Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain:

During FY '08 HSAG validated eleven mental health performance indicators and one substance abuse indicator for each PIHP. [Note: CMS has received the final report on the EQR for Years 1-4] HSAG conducted these evaluations through on-site review and documentation review. HSAG determined whether each measure was fully valid, substantially valid or not valid.

Summary of results

For Year 4, seventeen PIHPs were either fully valid or substantially valid on all twelve indicators. The remaining PIHP was evaluated as 'not valid' on just one of their indicators. This represents significant improvement from the Year 1 evaluation in which only three PIHPs were either fully valid or substantially valid on the ten indicators that were validated. As part of the External Quality Review, HSAG noted improvement across many of the PIHPs in regard to better validation of the data and indicators, clearer documentation on how the indicators were calculated and greatly improved adherence to MDCH's codebook instructions. Several PIHPs implemented

new or updated existing data warehouses to increase data accuracy and reliability. The PIHPs demonstrated best practices in several areas, including implementation of an analytic tool, built-in edits for access screens, requirements for a corrective action plan for providers whose performance falls below the MDCH threshold, processes for oversight and verification of data completeness and assessment of data accuracy, and documentation of quality improvement processes, information systems, and performance measure calculation processes.

Problems identified

HSAG's recommendations for improvement primarily addressed increased automation of performance measure calculations, increased audit processes to ensure the uniform collection of all indicators, and verification of the accuracy of claims and encounter data. HSAG recommended that the PIHPs continue to increase the number of providers submitting claims electronically and implement system enhancements such as drop-down boxes to improve documentation of exclusions.

Corrective action (plan/provider level)

Each PIHP received their evaluation during the fall 2008. HSAG is currently reviewing their progress during the FY'09 EQR process.

Program change (system-wide level)

FY06 was the first year that MDCH had implemented the performance indicators that were revised in coordination with the Quality Improvement Council (QIC). As noted in the previous waiver, QIC and MDCH selected those indicators that appeared to be the most valid and reliable for assessing system quality and developed a revised codebook to clarify those instructional issues identified by HSAG during Year 1. The list of performance indicators implemented since FY'06 is contained in Attachment A.III.1: Strategy for Assessing and Improving the Quality of Managed Specialty Services and Supports.

Strategy: External Quality Review
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:

Summary of results

External Quality Review. For the October 2007 to September 2008 review period Health Services Advisory Group (HSAG) conducted a follow-up review on compliance with BBA standards in seven areas: subcontracts and delegation, provider network, credentialing, access and availability, coordination of care, appeals, and advanced directives.

After the follow-up review, the statewide average of the PIHP's scoring was 99% for subcontracts and delegation, 100% for provider network and coordination of care, 97% for advanced directives, and 99% for credentialing. Compliance with the appeals requirements was slightly less at 95% and the access and availability was scored at 88%. The latter score reflected the difficulty a few of the PIHPs had with meeting MDCH established timeliness and access performance standards in such areas as pre-admission screenings, non-emergency face-to-face assessments, beginning new services, and follow-up care after discharge from psychiatric hospitals or substance abuse detoxification units.

For the October 2008 to September 2009 review period, HSAG is reviewing PIHP compliance with all BBA Compliance Monitoring Standards. Based on past performance, PIHPs either had a desk audit and telephone conference, or a desk audit coupled with an on-site review. The process of issuing final reports is about half-way complete and HSAG is scheduled to provide MDCH with the 2008-2009 External Quality Review Technical Report by October 1, 2009.

Problems identified

PIHP performance on BBA compliance related measures is quite strong. The access and availability section is the lowest scoring area when looked at from a statewide average perspective. As noted above, this score reflects the difficulty some of the PIHPs have experienced in meeting 95% performance indicator standards related to certain screening, assessment, service commencement, and follow-up activities.

Corrective action (plan/provider level)

HSAG and MDCH continue to work together to effectively evaluate and improve PIHP performance in this area. PIHPs that have less than a full compliance score are required to submit a plan of correction to MDCH. Both HSAG and MDCH will evaluate the effectiveness of the corrective action plans: HSAG during its reviews in the October 2009-September 2010 time period, and MDCH during its next scheduled site review.

Program change (system-wide level): N/A.

Strategy: Application for Participation

Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain:

Summary of results

Nineteen CMHSPs applied to be selected as PIHP in 2002. The application included requirements derived from the Michigan Mental Health Code, the Specialty Services and Supports Waiver, and the then interim rules for the BBA. Following the document review, applicants were visited by teams of MDCH staff

to verify assurances and claims made in their responses. A panel appointed by the Governor made the final selection of 18 Pre-paid Inpatient Health Plans. Based on the document review and site visits, each of the 18 PIHPs had plans of correction. Two PIHPs' selection by the panel was provisional on completing specific corrections: Detroit-Wayne CMHSP and Lakeshore Affiliation (Muskegon CMHSP).

Problems identified

A panel appointed by the Governor made the final selection of 18 Pre-paid Inpatient Health Plans. Based on the document review and site visits, each of the 18 PIHPs had plans of correction. Two PIHPs' selection by the panel was provisional on completing specific corrections: Detroit-Wayne CMHSP and Lakeshore Affiliation (Muskegon CMHSP). Detroit-Wayne's primary problems were network monitoring and the de-centralized recipient rights system. Muskegon's primary problem was the refusal to implement self-determination.

Corrective action (plan/provider level)

In response to the provision status, Muskegon made assurances that it would implement self-determination during the fiscal year. MDCH staff provided intensive technical assistance during the FY'02-03 to Detroit-Wayne CMHSP. Numerous site visits were made by MDCH staff to ensure that corrections were being implemented. The remaining PIHPs were visited during the fiscal year by the MDCH Medicaid site review team during which the team review progress on plans of correction and met with the consumer advisory groups to determine if issues they had raised during the AFP site visits were being addressed.

Program change (system-wide level)

The MDCH site review processes have since continued to focus on elements of the AFP, and continued to meet with the consumer advisory groups.

Strategy: Service Agency Profiles

Confirmation it was conducted as described:

__X__ Yes

___ No. Please explain:

Summary of Results

With isolated exceptions, the site review team has found that the database contains current service agency profile information.

Problems Identified

There are occasional instances where service agency profile information has not been submitted or is not current.

Corrective action

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

a web-based service agency profile system that will allow for real time changes and data inquiries.

Program change

None

State of **Appendix D1. Member Months** .

Row # / Column Letter | B | C | D | E | F | G | H | I | J | K | L | M | N

Renewal Waiver

Estimated Member Month Calculations

State: **Michigan: FY 10-11 Renewal Request**

Actual Enrollment for the Time Period - R1 = 10/1/2007 through 9/30/2008 R2 = 10/1/2008 through 9/30/2009 **R1 and R2 include actual data and dates. No estimates. Minimum 5 Quarters needed for works

Enrollment Projections for the Time Period - P1 = 10/1/2009 through 9/30/2010 P2 = 10/1/2010 through 9/30/2011 *Projections start on a calendar quarter and include data for the entire requested waiver period

Medicaid Eligibility Group (MEG)	Retrospective Year 1 (R1) ends 9/30/2008	Retrospective Year 2 (R2) ends 9/30/2009	Projected Quarter 1 begins 10/1/2009	Projected Quarter 2 begins 1/1/2010	Projected Quarter 3 begins 4/1/2010	Projected Quarter 4 begins 7/1/2010	Projected Year 1 (P1)	Projected Quarter 5 begins 10/1/2010	Projected Quarter 6 begins 1/1/2011	Projected Quarter 7 begins 4/1/2011	Projected Quarter 8 begins 7/1/2011	Projected Year 2 (P2)	Total Projected (H+M)
MCHIP(Healthy Kids)	107,885	109,859	26,537	26,603	26,669	26,736	106,545	26,802	26,869	26,936	27,003	107,611	214,156
TANF	11,321,945	11,975,930	3,181,866	3,238,659	3,296,515	3,355,455	13,072,495	3,415,501	3,476,674	3,538,997	3,602,491	14,033,663	27,106,159
DAB	4,774,797	4,913,618	1,275,027	1,286,485	1,298,147	1,310,017	5,169,677	1,322,100	1,334,399	1,346,919	1,359,665	5,363,083	10,532,761
1915(c) Waiver Enrollees	91,863	90,568	22,642	22,642	22,642	22,642	90,568	22,642	22,642	22,642	22,642	90,568	181,136
Total Member Months	**16,296,490**	**17,089,975**	**4,506,072**	**4,574,389**	**4,643,974**	**4,714,850**	**18,439,286**	**4,787,045**	**4,860,584**	**4,935,494**	**5,011,801**	**19,594,925**	**38,034,211**
Quarterly % Increase				**1.52%**	**1.52%**	**1.53%**		**1.53%**	**1.54%**	**1.54%**	**1.55%**		
Annualized % Increase R1 to R2 to P1 to P2		**4.87%**					**7.90%**					**6.27%**	

Note tabs at bottom of spreadsheet - to print all charts select 'Entire Workbook' from print options.

Modify Line items as necessary to fit the MEGs of the program.

*Projections start on a calendar quarter and include data for the entire requested waiver period

**R1 and R2 include actual data and dates. No estimates. A minimum of 5 quarters of actual data is needed for these worksheets to calculate properly

NUMBER OF DAYS OF DATA	
R2	364.00
Gap (end of R2 to P1)	1.00
P1	364.00
P2	364.00
TOTAL R2 to P2	1093.00
(Days-365)	728.00
TOTAL R2 to P1	729
(Days-364)	364

State Completion Sections

Enter R1 and R2 counts from completed member months reports submitted to RO on quarterly basis.

Project P1 and P2 on a quarterly basis using R2 as base.

To modify the formulas as necessary to fit the length of the program complete this section. The formulas will automatically update given this data.

Use Quarter Starting Dates on Appendix D1. Appendix D6 will automatically become Quarter Ending Dates to sync with CMS-64.

Note: the calculations in the worksheet use greater detail than what is shown in printed tables or on the screen. This results in greater precision than if all calculations were rounded to the displayed currency settings. Using a calculator for hand calculation will show differences when summing larger numbers - the differences should not be significant.

sheet.

Appendix D2.S Services in Waiver Cost

Services in Actual Waiver Cost (Comprehensive and Expedited)

Michigan: FY 10-11 Renewal Request

Base Year Conversion Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note services in different MEC

***** Please note with a * if there are any proposed changes

Row # / Column Letter	B	C	D	E	F
8	**State Plan Services**				
9-12	**Service Category**	**State Plan Approved Services**	**1915(b)(3) Services**	**PIHP Capitated Reimbursement**	**FFS services Impacted by PIHP**
13	Day Treatment Services				
14	Dental	x			
15	Detoxification	x			
16	ICF/MR				
17	16+ beds: DD Centers	x			
18	4-16 bds: AIS/MR	x		x	
19	1915(c) HCBS/Hab Supports Waiver	x		x	
20	1915(c) HCBS/Children's Waiver	x			
21	1915(c) HCBS/SED Children's Waiver	x			
22	Mental Health Clinic Services	x		x	
23	Mental Health Rehab Services	x		x	
24	Mental Health Case Mgmt.	x		x	
25	Individualized Specialty Mental Health 1915(b)(3) Services:				
26	Assistive Technology		x	x	
27	~~Extended Observation Beds~~Retitled: Crisis Observation Care		x	x	
28	Housing Assistance		x	x	
29	Prevention-Direct Service Models		x	x	
30	Peer-Delivered or -Operated Support Services		x	x	
31	Wraparound Services for Children and Adolescents		x	x	
32	Community Living Supports		x	x	
33	Enhanced Pharmacy		x	x	
34	Environmental Modifications		x	x	
35	Family Support and Training		x	x	
36	Respite Care Services		x	x	
37	Skill Building Assistance		x	x	
38	Fiscal Intermediary Services		x	x	
39	Supported/Integrated Employment Services		x	x	
40	Support and Service Coordination		x	x	
41	Individualized Specialty Substance Abuse 1915(b)(3) Services:				
42	Sub Acute Detoxification		x	x	
43	Residential Treatment		x	x	
44	Durable Medical Equipment	x			
45	Education Agency Services				
46	Emergency Service	x			
47	EPSDT				
48	Screening	x			
49	Specialty MH/DD/SA Corrective Services	x		x	
50	Family Planning Services	x			
51	Federally Qualified Health Center Services	x			
52	Home Health	x			
53	Hospice	x			
54	Inpatient Hospital - Psych	x		x	
55	Inpatient Hospital - Other	x			
56	Immunizations	x			
57	Lab and x-ray	x			
58	Nurse midwife	x			
59	Nurse practitioner	x			
60	Nursing Facility	x			
61	Obstetrical services	x			
62	Occupational therapy	x			
63	Other fee-for-service services				
64	Other Outpatient Services -- Please Specify				
65	Other Psych Practitioner				
66	Outpatient Hospital - All Other	x			
67	Outpatient Hospital - Lab & X-ray	x			
68	Partial Hospitalization	x		x	
69	Personal Care				
70	(In licensed Specialized Mental Health facilities)	x		x	
71	Pharmacy	x			x
72	Physical Therapy	x			
73	Physician	x			
74	Private duty nursing (Beneficiaries < 21 years)	x			
75	Prof. & Clinic and other Lab and X-ray				
76	Psychologist				
77	Rehabilitation Treatment Services				
78	(Specialty Mental Health and DD Only)	x		x	
79	Respiratory care	x			
80	Rural Health Clinic	x			
81	Speech Therapy	x			
82	Substance Abuse Treatment Services	x		x	
83	Testing for sexually transmitted diseases (STDs)	x			
84	Transportation - Emergency	x			
85	Transportation - Non-emergency	x			
86	Vision Exams and Glasses				
87	Other -- Please specify				
88	Other Pharmacy Services -- Please specify (e.g., Health Drugs)				
89	Other Mental Health Services				
90	Other Inpatient Services - Please Specify				

93 Modify Line items as necessary to fit the services of the program.

94 State Completion Sections

Appendix D2.A Administration in Waiver Cost

Administration in Actual Waiver Cost (Comprehensive and Expedited)

State: Michigan: FY 10-11 Renewal Request

Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note administration in different MEGs, etc.

CMS 64.10 line Item	CMS 64.10 Explanation	Contract	Match Rate	R1 Expenses	R2 Expenses
1	FAMILY PLANNING		90% FFP		
2	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS*		90% FFP		
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		90% FFP		
B.	COST OF PRIVATE SECTOR CONTRACTORS		90% FFP		
C.	DRUG CLAIMS SYSTEM		90% FFP		
3	SKILLED PROFESSIONAL MEDICAL PERSONNEL		75% FFP		
4	OPERATION OF AN APPROVED MMIS*:		75% FFP		
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		75% FFP	$ 74,298	$ 83,577
B.	COST OF PRIVATE SECTOR CONTRACTORS		75% FFP		
	Psychotropic & Side Effects Drug Claims Processing Fees - First Health		50% FFP	$ 290,710	$ 318,003
5	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES:		50% FFP		
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		50% FFP		
B.	COST OF PRIVATE SECTOR CONTRACTORS		50% FFP		
6	PEER REVIEW ORGANIZATIONS (PRO)		75% FFP		
7.A.	THIRD PARTY LIABILITY RECOVERY PROCEDURE - BILLING OFFSET		50% FFP		
B.	ASSIGNMENT OF RIGHTS - BILLING OFFSET		50% FFP		
8	IMMIGRATION STATUS VERIFICATION SYSTEM COSTS		100% FFP		
9	NURSE AIDE TRAINING COSTS		50% FFP		
10	PREADMISSION SCREENING COSTS		75% FFP		
11	RESIDENT REVIEW ACTIVITIES COSTS		75% FFP		
12	DRUG USE REVIEW PROGRAM - First Health Clinical Consult DUR Fees		75% FFP	$ 52,034	$ 27,985
13	OUTSTATIONED ELIGIBILITY WORKERS		50% FFP		
14.	TANF BASE		90% FFP		
15.	TANF SECONDARY 90%		90% FFP		
16.	TANF SECONDARY 75%		75% FFP		
17.	EXTERNAL QUALITY REVIEW - HAS Group EQRO		75% FFP	$ 373,458	$ -
18.	ENROLLMENT BROKERS		50% FFP		
19.	OTHER FINANCIAL PARTICIPATION		50% FFP		
	MI Department of Community Health Staff Waiver Adm. Activity - Per Cost Allocation Plan		50% FFP	$ 3,385,883	$ 2,367,708
	Psychotropic & Side Effects Drug Rebates Processing Fees - First Health		50% FFP	$ 60,132	$ 83,557
	Renewal Preparation & Implementation Consultation - Harrison Contract		50% FFP	$ 40,817	$ 403,432
	Actuarial Services: Rates Development/Certification - Milliman, Inc.		50% FFP	$ 54,769	$ 150,000
	Wayne State University - MPC Exit Monitors		50% FFP	$ -	$ 9,188
20	Total			**$ 4,332,100**	***$ 3,443,450***

*Allocation basis is ___% of Medicaid costs OR ___ % of Medicaid eligibles OR ___ other, please explain:

Add multiple line items as necessary to fit the administration of the program (i.e. if you have more than one contract on line 19, detail the contracts separately).

State Completion Sections Enter in amounts from Schedule F on the MBES system.

Appendix D3. Actual Waiver Cost

Actual Waiver Cost Renewal Comprehensive Version

State: Michigan: FY 10-11 Renewal Request

Medicaid Eligibility Group (MEG)	R1 Member Months	Retrospective Year 1 (R1) Aggregate Costs: MCO/PIHP Capitated Costs risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs	Total Actual Waiver Costs (F+G+H+I)
MCHIP(Healthy Kids)	107,885	$ 1,138,244	$ 164,812	$ 1,303,056		$ 206,674	$ 28,679	**$ 1,538,409**
TANF	11,321,945	$ 115,209,249	$ 20,024,412	$ 135,233,662		$ 20,908,353	$ 3,009,715	**$ 159,151,730**
DAB	4,774,797	$ 647,794,240	$ 71,676,123	$ 719,470,363		$ 543,059,481	$ 1,269,285	**$ 1,263,799,130**
1915(c) Waiver Enrollees	91,863	$ 396,416,507	$ -	$ 396,416,507		$ -	$ 24,420	**$ 396,440,927**
Total	**16,296,490**	**$ 1,160,558,240**	**$ 91,865,347**	**$ 1,252,423,588**	**$ -**	**$ 564,174,508**	**$ 4,332,100**	**$ 1,820,930,196**
R1 Overall PMPM Casemix for R1 (R1 MMs)								

Medicaid Eligibility Group (MEG)	R2 Member Months	Retrospective Year 2 (R2) Aggregate Costs: MCO/PIHP Capitated Costs risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs (Attach list using CMS 64.10 Waiver schedule categories)	Total Actual Waiver Costs (F+G+H+I)
MCHIP(Healthy Kids)	109,859	$ 1,223,572	$ 231,534	$ 1,455,106		$ 219,908	$ 22,135	**$ 1,697,150**
TANF	11,975,930	$ 129,784,440	$ 23,420,063	$ 153,204,504		$ 23,423,972	$ 2,413,024	**$ 179,041,499**
DAB	4,913,618	$ 693,455,133	$ 72,774,501	$ 766,229,634		$ 583,136,065	$ 990,042	**$ 1,350,355,741**
1915(c) Waiver Enrollees	90,568	$ 400,431,016	$ -	$ 400,431,016		$ -	$ 18,249	**$ 400,449,265**
Total	**17,089,975**	**$ 1,224,894,161**	**$ 96,426,098**	**$ 1,321,320,260**	**$ -**	**$ 606,779,945**	**$ 3,443,450**	**$ 1,931,543,655**
R1 Overall PMPM Casemix for R2 (R2 MMs)						7.55%		

Modify Line items as necessary to fit the MEGs of the program. $ 1,170,954,453

State Completion Sections: For a State without FFS incentives or 1915(b)(3), enter in amounts from Schedule F from the MBES (Capitated - Column D versus FFS - Column E) and ensure that Column F matches services
If the State has 1915(b)(3) or FFS incentives, use State ad hoc reports to calculated amountes in Columns G and H and to reduce the amounts in columns D and E.
For these comprehensive states, the total from Columns D, E, G, and H should equal the services amounts in Schedule D from the MBES.
Note: The States completing the Expedited Test will only attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 W
Completion of this Appendix is not necessary for expedited waivers.
Note: The States completing the Comprehensive Test will attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 W
Completion of this Appendix is required for Comprehensive Waivers.

Row # / Column Letter | B | C | K | L | M | N | O

Actual Waiver Cost Renewal Comprehensive Version

State: Michigan: FY 10-11 Renewal Request

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 Per Member Per Month (PMPM) Costs: State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
MCHIP(Healthy Kids)	107,885	$ 12.08	$ -	$ 1.92	$ 0.27	**$ 14.26**
TANF	11,321,945	$ 11.94	$ -	$ 1.85	$ 0.27	**$ 14.06**
DAB	4,774,797	$ 150.68	$ -	$ 113.73	$ 0.27	**$ 264.68**
1915(c) Waiver Enrollees	91,863	$ 4,315.30	$ -	$ -	$ 0.27	**$ 4,315.57**
Total	**16,296,490**					
R1 Overall PMPM Casemix for R1 (R1 MMs)		**$ 76.85**	**$ -**	**$ 34.62**	**$ 0.27**	**$ 111.74**

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 Per Member Per Month (PMPM) Costs: State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
MCHIP(Healthy Kids)	109,859	$ 13.25	$ -	$ 2.00	$ 0.20	**$ 15.45**
TANF	11,975,930	$ 12.79	$ -	$ 1.96	$ 0.20	**$ 14.95**
DAB	4,913,618	$ 155.94	$ -	$ 118.68	$ 0.20	**$ 274.82**
1915(c) Waiver Enrollees	90,568	$ 4,421.33	$ -	$ -	$ 0.20	**$ 4,421.53**
Total	**17,089,975**					
R1 Overall PMPM Casemix for R2 (R2 MMs)		**$ 77.32**	**$ -**	**$ 35.51**	**$ 0.20**	**$ 113.02**

Modify Line items as necessary to fit the MEGs

State Completion Sections: For a State without costs in Schedule D from the MBES.

If the State has 1915(b)(3) or FFS incentives, u

For these comprehensive states, the total from (

Note: The States completing the Expedited Test Waiver.

Completion of this Appendix is not necessary fo

Note: The States completing the Comprehensiv Waiver.

Completion of this Appendix is required for Com

State of

Appendix D4. Adjustments in Projection

Row # / Column Letter	B	C	D
2	**Adjustments and Services in Waiver Cost Projection (Comprehensive and Expedited)**		
3	**State:**	**Michigan: FY 10-11 Renewal Request**	
4	**Prospective Years 1 and 2 (P1 and P2)**		
5	**Renewal Waiver**		
6	*** If a change please note**		
7			

	Adjustments to the Waiver Cost Projection	Adjustments Made	Location of Adjustment
8			
9	State Plan Trend	X	Tab: D5; Column J; Row 13 - 16, 30 - 33
10	State Plan Programmatic/policy/pricing changes	X	Tab: D5; Column L; Row 13 - 16, *30 - 33
11	Administrative Cost Adjustment	X	Tab D5; Column Y; Row 13 - 16, 30 - 33
12	1915(b)(3) service Trend	X	Tab: D5; Column U; Rows 13 - 15; Rows 30 - 32
13	Incentives (not in cap payment) Adjustments		
14	Other		
15			

State Completion Sections

State of

Appendix D5. Waiver Cost Projection

Waiver Cost Projection Renewal Waiver Comprehensive Version
State: Michigan: FY 10-11 Renewal Request
Note: Complete this Appendix for all Prospective Years
Waiver Cost Projection

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	R2 Per Member Per Month (PMPM) Costs: State Plan Service Costs*	Incentive Costs*	1915(b)(3) Service Costs*	Administration Costs*	Total Actual Waiver Costs*	Prospective Year 1 (P1) Projection for State Plan Services**: R2 PMPM State Plan Service Costs* (Same as D13-D18)	State Plan Inflation Adjustment (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (IxJ)	Program Adjustment Capitation Rate Change (Preprint Explains)	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P1 PMPM State Plan Service Cost Projection (I+N)
MCHIP(Healthy Kids)	109,859	$ 13.25	$ -	$ 2.00	$ 0.20	$ 15.45	$ 13.25	3.18%	$ 0.42	3.76%	$ 0.51	$ 0.93	$ 14.18
TANF	11,975,930	$ 12.79	$ -	$ 1.96	$ 0.20	$ 14.95	$ 12.79	2.60%	$ 0.33	11.22%	$ 1.47	$ 1.81	$ 14.60
DAB	4,913,618	$ 155.94	$ -	$ 118.68	$ 0.20	$ 274.82	$ 155.94	0.71%	$ 1.11	5.18%	$ 8.13	$ 9.24	$ 165.18
1915(c) Waiver Enrollees	90,568	$ 4,421.33	$ -	$ -	$ 0.20	$ 4,421.53	$ 4,421.33	0.00%	$ -	5.31%	$ 234.59	$ 234.59	$ 4,655.92
Total	**17,089,975**			**6,700**									
P1 PMPM Casemix for R2 (R2 MMs)		**$ 77.32**	**$ -**	**$ 35.51**	**$ 0.20**	**$ 113.02**	**$ 77.32**	**0.72%**	**$ 0.56**	**5.9%**	**$ 4.62**	**$ 5.17**	**$ 82.49**

* For comprehensive waivers, Columns D, E, F, G and H are columns K, L, M, N, and O from the Actual Waiver Cost Spreadsheet D3. For expedited waivers, sum the CMS-64.9 WAV and 64.21UWAV forms and divide by the member months for column D. Sum the CMS 64.10 WAV forms and divide by the member months for Column G. Sum D+G for Column H.
** If additional columns are needed in order to identify all of the adjustments being made, please insert the appropriate number of columns and label them accordingly.

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P1 Per Member Per Month (PMPM) Costs: P1 PMPM State Plan Service Costs (same as O13-O18)	P1 PMPM Incentive Service Costs (same as S13-S18)	P1 PMPM 1915(b)(3) Service Cost Projection (same as W13-W18)	P1 PMPM Administration Cost Projection (same as AA13-AA18)	P1 PMPM Total Actual Waiver Costs (same as AB13-AB18)	Prospective Year 2 (P2) Projection for State Plan Services**: P1 PMPM State Plan Service Cost Projection (Same as D30-D35)	State Plan Inflation Adjustment (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (IxJ)	Program Adjustment Capitation Rate Change (Preprint Explains)	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P2 PMPM State Plan Service Cost Projection (I+N)
MCHIP(Healthy Kids)	109,859	$ 14.18	$ -	$ 2.12	$ 0.30	$ 16.60	$ 14.18	7.68%	$ 1.09	0.00%	$ -	$ 1.09	$ 15.27
TANF	11,975,930	$ 14.60	$ -	$ 2.23	$ 0.30	$ 17.13	$ 14.60	7.09%	$ 1.04	0.00%	$ -	$ 1.04	$ 15.63
DAB	4,913,618	$ 165.18	$ -	$ 125.30	$ 0.30	$ 290.79	$ 165.18	5.87%	$ 9.69	0.00%	$ -	$ 9.69	$ 174.87
1915(c) Waiver Enrollees	90,568	$ 4,655.92	$ -	$ -	$ 0.30	$ 4,656.23	$ 4,655.92	3.23%	$ 150.27	0.00%	$ -	$ 150.27	$ 4,806.19
Total	**17,089,975**												
P2 PMPM Casemix for R2 (R2 MMs)		**$ 82.49**	**$ -**	**$ 37.60**	**$ 0.30**	**$ 120.39**	**$ 82.49**	**5.23%**	**$ 4.31**	**0.0%**	**$ -**	**$ 4.31**	**$ 86.80**

Modify Line items as necessary to fit the MEGs of the program.
State Completion Sections

State of

Appendix D5. Waiver Cost Projection

State: Michigan: FY 10-11 Renewal Request

Medicaid Eligibility Group (MEG)	P1 Projection for Incentive Costs not Included in Capitation Rates**				P1 Projection for 1915(b)(3) Service Costs**				P1 Projection for Administration Costs**				Total P1 PMPM Projected Waiver Costs (O+S+W+AA)
	R2 PMPM Incentive Costs* (Same as E13-E18)	Incentive Cost Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P1 PMPM Incentive Cost Projection (P+R)	R2 PMPM 1915(b)(3) Service Costs* (Same as F13-F18)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P1 PMPM 1915(b)(3) Service Cost Projection (T+V)	R2 PMPM Administration Costs* (Same as G13-G18)	Administration Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (XxY)	Total P1 PMPM Administration Cost Projection (X+Z)	
MCHIP(Healthy Kids)	$ -		$ -	$ -	$ 2.00	5.72%	$ 0.11	$ 2.12	$ 0.20	50.00%	$ 0.10	$ 0.30	**$ 16.60**
TANF	$ -		$ -	$ -	$ 1.96	14.09%	$ 0.28	$ 2.23	$ 0.20	50.00%	$ 0.10	$ 0.30	**$ 17.13**
DAB	$ -		$ -	$ -	$ 118.68	5.58%	$ 6.63	$ 125.30	$ 0.20	50.00%	$ 0.10	$ 0.30	**$ 290.79**
1915(c) Waiver Enrollees	$ -		$ -	$ -	$ -		$ -	$ -	$ 0.20	50.00%	$ 0.10	$ 0.30	**$ 4,656.23**
Total													
P1 PMPM Casemix for R2 (R2 MMs)	**$ -**	**0.00%**	**$ -**	**$ -**	**$ 35.51**	**5.91%**	**$ 2.10**	**$ 37.60**	**$ 0.20**	**50.00%**	**$ 0.10**	**$ 0.30**	**$ 120.39**

Medicaid Eligibility Group (MEG)	P2 Projection for Incentive Costs not Included in Capitation Rates**				P2 Projection for 1915(b)(3) Service Costs**				P2 Projection for Administration Costs**				Total P2 PMPM Projected Waiver Costs (O+S+W+AA)
	P1 PMPM Incentive Cost Projection (Same as E30-E35)	Incentive Cost Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P2 PMPM Incentive Cost Projection (P+R)	P1 PMPM 1915(b)(3) Service Cost Projection (Same as F30-F35)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P2 PMPM 1915(b)(3) Service Cost Projection (T+V)	P1 PMPM Administration Cost Projection (Same as G30-G35)	Administration Costs Inflation Adj. (Annual Year 2)	PMPM Effect of Inflation Adjustment (XxY)	Total P2 PMPM Administration Cost Projection (X+Z)	
MCHIP(Healthy Kids)	$ -		$ -	$ -	$ 2.12	5.00%	$ 0.11	$ 2.22	$ 0.30	4.00%	$ 0.01	$ 0.31	**$ 17.80**
TANF	$ -		$ -	$ -	$ 2.23	5.29%	$ 0.12	$ 2.35	$ 0.30	4.00%	$ 0.01	$ 0.31	**$ 18.30**
DAB	$ -		$ -	$ -	$ 125.30	5.69%	$ 7.13	$ 132.43	$ 0.30	4.00%	$ 0.01	$ 0.31	**$ 307.61**
1915(c) Waiver Enrollees	$ -		$ -	$ -	$ -	0.00%	$ -	$ -	$ 0.30	4.00%	$ 0.01	$ 0.31	**$ 4,806.51**
Total													
P2 PMPM Casemix for R2 (R2 MMs)	**$ -**	**0.00%**	**$ -**	**$ -**	**$ 37.60**	**5.67%**	**$ 2.13**	**$ 39.74**	**$ 0.30**	**4.00%**	**$ 0.01**	**$ 0.31**	**$ 126.85**

Modify Line items as necessary to fit the MEGs of the program.
State Completion Sections

Row # / Column Letter | B | C | D | E | F | G | H | I | J | K | L | M | N | O

Quarterly CMS Targets for RO Monitoring

State: Michigan: FY 10-11 Renewal Request

Projection for Upcoming Waiver Period

Projected Year 1

Medicaid Eligibility Group (MEG)	Total Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 1 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
MCHIP(Healthy Kids)	106,545	$ 14.18	$ -	$ 2.12	$ 0.30	$ 16.60	$ 16.30
TANF	13,072,495	$ 14.60	$ -	$ 2.23	$ 0.30	$ 17.13	$ 16.83
DAB	5,169,677	$ 165.18	$ -	$ 125.30	$ 0.30	$ 290.79	$ 290.48
1915(c) Waiver Enrollees	90,568	$ 4,655.92	$ -	$ -	$ 0.30	$ 4,656.23	$ 4,655.92
Total	**18,439,286**						
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 79.61**	**$ -**	**$ 36.72**	**$ 0.30**	**$ 116.64**	**$ 116.33**

Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs			Q2 Quarterly Projected Costs			Q3 Quarterly Projected Costs			Q4 Quarterly Projected Costs			Total P1 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
MCHIP(Healthy Kids)	26,537	$ 432,451.41	$ 8,020.38	26,603	$ 433,528.50	$ 8,040.36	26,669	$ 434,608.28	$ 8,060.38	26,736	$ 435,690.75	$ 8,080.46	**$ 1,768,480.53**
TANF	3,181,866	$ 53,549,424.48	$ 961,668.86	3,238,659	$ 54,505,221.23	$ 978,833.57	3,296,515	$ 55,478,915.04	$ 996,319.67	3,355,455	$ 56,470,856.34	$ 1,014,133.48	**$ 223,955,372.68**
DAB	1,275,027	$ 370,373,935.99	$ 385,356.92	1,286,485	$ 373,702,287.17	$ 388,819.91	1,298,147	$ 377,089,882.56	$ 392,344.55	1,310,017	$ 380,537,933.67	$ 395,932.09	**$ 1,503,266,492.87**
1915(c) Waiver Enrollees	22,642	$ 105,419,434.76	$ 6,843.19	22,642	$ 105,419,434.76	$ 6,843.19	22,642	$ 105,419,434.76	$ 6,843.19	22,642	$ 105,419,434.76	$ 6,843.19	**$ 421,705,111.79**
Total	**4,506,072**	**$ 529,775,246.63**	**$ 1,361,889.35**	**4,574,389**	**$ 534,060,471.67**	**$ 1,382,537.03**	**4,643,974**	**$ 538,422,840.65**	**$ 1,403,567.80**	**4,714,850**	**$ 542,863,915.53**	**$ 1,424,989.22**	**$ 2,150,695,457.87**

Projected Year 2

Medicaid Eligibility Group (MEG)	Total Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 2 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
MCHIP(Healthy Kids)	107,611	$ 15.27	$ -	$ 2.22	$ 0.31	$ 17.80	$ 17.49
TANF	14,033,663	$ 15.63	$ -	$ 2.35	$ 0.31	$ 18.30	$ 17.98
DAB	5,363,083	$ 174.87	$ -	$ 132.43	$ 0.31	$ 307.61	$ 307.30
1915(c) Waiver Enrollees	90,568	$ 4,806.19	$ -	$ -	$ 0.31	$ 4,806.51	$ 4,806.19
Total	**19,594,925**						
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**$ 81.36**	**$ -**	**$ 37.94**	**$ 0.31**	**$ 119.61**	**$ 119.30**

Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs			Q6 Quarterly Projected Costs			Q7 Quarterly Projected Costs			Q8 Quarterly Projected Costs			Total P2 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
MCHIP(Healthy Kids)	26,802	$ 468,782.47	$ 8,424.61	26,869	$ 469,950.06	$ 8,445.59	26,936	$ 471,120.56	$ 8,466.63	27,003	$ 472,293.97	$ 8,487.71	**$ 1,915,971.60**
TANF	3,415,501	$ 61,421,418.95	$ 1,073,572.66	3,476,674	$ 62,521,502.62	$ 1,092,800.80	3,538,997	$ 63,642,254.34	$ 1,112,390.20	3,602,491	$ 64,784,080.07	$ 1,132,347.94	**$ 256,780,367.59**
DAB	1,322,100	$ 406,278,321.80	$ 415,567.17	1,334,399	$ 410,057,829.68	$ 419,433.09	1,346,919	$ 413,905,305.16	$ 423,368.53	1,359,665	$ 417,822,143.62	$ 427,374.92	**$ 1,649,749,343.96**
1915(c) Waiver Enrollees	22,642	$ 108,821,787.90	$ 7,116.92	22,642	$ 108,821,787.90	$ 7,116.92	22,642	$ 108,821,787.90	$ 7,116.92	22,642	$ 108,821,787.90	$ 7,116.92	**$ 435,315,619.27**
Total	**4,787,045**	**$ 576,990,311.13**	**$ 1,504,681.35**	**4,860,584**	**$ 581,871,070.26**	**$ 1,527,796.40**	**4,935,494**	**$ 586,840,467.96**	**$ 1,551,342.27**	**5,011,801**	**$ 591,900,305.56**	**$ 1,575,327.49**	**$ 2,343,761,302.42**

P Q R S T U

Quarterly CMS Targets for RO CMS-64 Review Renewal

State: Michigan: FY 10-11 Renewal Request

Projection for Upcoming Waiver Period

Projections for RO CMS-64 Certification - Aggregate Cost

Projected Year 1 10/1/2009 through 9/30/2010

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Quarter Ending (QE) 12/31/2009	Q2 Quarterly Projected Costs Quarter Ending (QE) 3/31/2010	Q3 Quarterly Projected Costs Quarter Ending (QE) 6/30/2010	Q4 Quarterly Projected Costs Quarter Ending (QE) 9/30/2010
64.21U Waiver Form	MCHIP(Healthy Kids)	$ 432,451.41	$ 433,528.50	$ 434,608.28	$ 435,690.75
64.21U Waiver Form	TANF	$ 53,549,424.48	$ 54,505,221.23	$ 55,478,915.04	$ 56,470,856.34
64.9 Waiver Form	DAB	$ 370,373,935.99	$ 373,702,287.17	$ 377,089,882.56	$ 380,537,933.67
64.9 Waiver Form	1915(c) Waiver Enrollees	$ 105,419,434.76	$ 105,419,434.76	$ 105,419,434.76	$ 105,419,434.76
64.10 Waiver Form		$ 1,361,889.35	$ 1,382,537.03	$ 1,403,567.80	$ 1,424,989.22

Projected Year 1 10/1/2010 through 9/30/2011

Waiver Form	Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs Quarter Ending (QE) 12/31/2010	Q6 Quarterly Projected Costs Quarter Ending (QE) 3/31/2011	Q7 Quarterly Projected Costs Quarter Ending (QE) 6/30/2011	Q8 Quarterly Projected Costs Quarter Ending (QE) 9/30/2011
64.21U Waiver Form	MCHIP(Healthy Kids)	$ 468,782.47	$ 469,950.06	$ 471,120.56	$ 472,293.97
64.21U Waiver Form	TANF	$ 61,421,418.95	$ 62,521,502.62	$ 63,642,254.34	$ 64,784,080.07
64.9 Waiver Form	DAB	$ 406,278,321.80	$ 410,057,829.68	$ 413,905,305.16	$ 417,822,143.62
64.9 Waiver Form	1915(c) Waiver Enrollees	$ 108,821,787.90	$ 108,821,787.90	$ 108,821,787.90	$ 108,821,787.90
64.10 Waiver Form		$ 1,504,681.35	$ 1,527,796.40	$ 1,551,342.27	$ 1,575,327.49

State of

Appendix D6. RO Targets

V W X Y Z AA AB AC AD AE AF AG AH AI

Quarterly CMS Targets for RO Cost-Effectiveness Monitoring

State: Michigan: FY 10-11 Renewal Request

Projection for Upcoming Waiver Period

Worksheet for RO PMPM Cost-Effectiveness Monitoring

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.21U Waiver Form	MCHIP(Healthy Kids)	$ 16.30
64.21U Waiver Form	TANF	$ 16.83
64.9 Waiver Form	DAB	$ 290.48
64.9 Waiver Form	1915(c) Waiver Enrollees	$ 4,655.92
64.10 Waiver Form	All MEGS	$ 0.30

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q1 Quarterly Actual Costs Member Months Actuals for QE 12/31/09	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q2 Quarterly Actual Costs Member Months Actuals for QE 03/31/10	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q3 Quarterly Actual Costs Member Months Actuals for QE 06/30/10	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q4 Quarterly Actual Costs Member Months Actuals for QE 09/30/10	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	MCHIP(Healthy Kids)			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.21U Waiver Form	TANF			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	DAB			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	1915(c) Waiver Enrollees			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission P1 Projected PMPM From Column I (services) From Column G (Administration)
64.21U Waiver Form	MCHIP(Healthy Kids)	$ 17.49
64.21U Waiver Form	TANF	$ 17.98
64.9 Waiver Form	DAB	$ 307.30
64.9 Waiver Form	1915(c) Waiver Enrollees	$ 4,806.19
64.10 Waiver Form	All MEGS	$ 0.31

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring Q5 Quarterly Actual Costs Member Months Actuals for QE 12/31/10	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q6 Quarterly Actual Costs Member Months Actuals for QE 03/31/11	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q7 Quarterly Actual Costs Member Months Actuals for QE 06/30/11	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	RO Completion Section - For ongoing monitoring Q8 Quarterly Actual Costs Member Months Actuals for QE 09/30/11	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	MCHIP(Healthy Kids)			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.21U Waiver Form	TANF			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	DAB			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.9 Waiver Form	1915(c) Waiver Enrollees			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Appendix D7. Summary

Cost Effectiveness Summary Sheet Renewal Waiver

State: Michigan: FY 10-11 Renewal Request

Costs to be input below are from the prior waiver submission. Compare the prospective years from the prior waiver submission to the retrospective years of the current waiver submission.*

Retrospective Period

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 PMPM State Plan Service Costs	R1 PMPM Incentive Costs	R1 PMPM 1915(b)(3) Service Costs	R1 PMPM Administration Costs	R1 PMPM Total Actual Waiver Costs
MCHIP(Healthy Kids)	107,885	$ 12.08	$ -	$ 1.92	$ 0.27	$ 14.26
TANF	11,321,945	$ 11.94	$ -	$ 1.85	$ 0.27	$ 14.06
DAB	4,774,797	$ 150.68	$ -	$ 113.73	$ 0.27	$ 264.68
1915(c) Waiver Enrollees	91,863	$ 4,315.30	$ -	$ -	$ 0.27	$ 4,315.57
Total	**16,296,490**					
R1 Overall PMPM Casemix for R1 (R1 MMs)		**$ 76.85**	**$ -**	**$ 34.62**	**$ 0.27**	**$ 111.74**
Total R1 Expenditures						**$1,820,930,196**

P1 PMPM State Plan Service Costs	P1 PMPM Incentive Costs	P1 PMPM 1915(b)(3) Service Costs	P1 PMPM Administration Costs	P1 PMPM Total Actual Waiver Costs
$ 12.08	$ -	$ 1.92	$ 0.29	$ 14.29
$ 11.94	$ -	$ 1.85	$ 0.29	$ 14.08
$ 150.68	$ -	$ 113.73	$ 0.29	$ 264.71
$ 4,315.30	$ -	$ -	$ 0.29	$ 4,315.59
$ 76.85	**$ -**	**$ 34.62**	**$ 0.29**	**$ 111.76**
Total Previous P1 Projection using R1 member months				**$1,821,330,794**

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 PMPM State Plan Service Costs	R2 PMPM Incentive Costs	R2 PMPM 1915(b)(3) Service Costs	R2 PMPM Administration Costs	R2 PMPM Total Actual Waiver Costs	Overall R1 to R2 Change (annual)
MCHIP(Healthy Kids)	109,859	$ 13.25	$ -	$ 2.00	$ 0.20	**$ 15.45**	**11.3%**
TANF	11,975,930	$ 12.79	$ -	$ 1.96	$ 0.20	**$ 14.95**	**8.6%**
DAB	4,913,618	$ 155.94	$ -	$ 118.68	$ 0.20	**$ 274.82**	**5.1%**
1915(c) Waiver Enrollees	90,568	$ 4,421.33	$ -	$ -	$ 0.20	**$ 4,421.53**	**3.3%**
Total	**17,089,975**						
R2 Weighted Average PMPM Casemix for R1 (R1 MMs)		**$ 79.59**	**$ -**	**$ 36.14**	**$ 0.20**	**$ 115.93**	**5.0%**
R2 OVerall PMPM Casemix for R2 (R2 MMs)		**$ 77.32**	**$ -**	**$ 35.51**	**$ 0.20**	**$ 113.02**	**1.5%**
Total R2 Expenditures						**$1,931,543,655**	

P2 PMPM State Plan Service Costs	P2 PMPM Incentive Costs	P2 PMPM 1915(b)(3) Service Costs	P2 PMPM Administration Costs	P2 PMPM Total Actual Waiver Costs
$ 14.09	$ -	$ 2.07	$ 0.30	$ 16.46
$ 13.39	$ -	$ 2.02	$ 0.30	$ 15.71
$ 158.77	$ -	$ 119.03	$ 0.30	$ 278.11
$ 4,542.51	$ -	$ -	$ 0.30	$ 4,542.82
$ 79.19	**$ -**	**$ 35.65**	**$ 0.30**	**$ 115.15**
Total Previous P2 Projection using R2 member months				**$1,967,851,856**

Total Previous Waiver Period Expenditures (Casemix for R1 and R2)	**$3,752,473,850**	**$3,789,182,650**
Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period	**$36,708,800**	

*** These PMPM's were provided to/approved by CMS in May 2009.**

Prospective Period

Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)	P1 PMPM State Plan Service Cost Projection	P1 PMPM Incentive Cost Projection	P1 PMPM 1915(b)(3) Service Cost Projection	P1 PMPM Administration Cost Projection	P1 PMPM Projected Waiver Costs	Overall R2 to P1 Change (annual)
MCHIP(Healthy Kids)	106,545	$ 14.18	$ -	$ 2.12	$ 0.30	$ 16.60	**5.91%**
TANF	13,072,495	$ 14.60	$ -	$ 2.23	$ 0.30	$ 17.13	**11.51%**
DAB	5,169,677	$ 165.18	$ -	$ 125.30	$ 0.30	$ 290.79	**4.62%**
1915(c) Waiver Enrollees	90,568	$ 4,655.92	$ -	$ -	$ 0.30	$ 4,656.23	**4.22%**
Total	**18,439,286**						
P1 Weighted Average PMPM Casemix for R2 (R2 MMs)		**$ 82.49**	**$ -**	**$ 37.60**	**$ 0.30**	**$ 120.39**	**5.18%**
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 79.61**	**$ -**	**$ 36.72**	**$ 0.30**	**$ 116.64**	**2.55%**
Total Projected Waiver Expenditures P1(P1 MMs)						**$2,150,695,458**	

$ 677,177,995.22
743,444,569

Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)	P2 PMPM State Plan Service Cost Projection	P2 PMPM Incentive Cost Projection	P2 PMPM 1915(b)(3) Service Cost Projection	P2 PMPM Administration Cost Projection	P2 PMPM Projected Waiver Costs	Overall P1 to P2 Change (annual)
MCHIP(Healthy Kids)	107,611	$ 15.27	$ -	$ 2.22	$ 0.31	$ 17.80	**7.27%**
TANF	14,033,663	$ 15.63	$ -	$ 2.35	$ 0.31	$ 18.30	**6.80%**
DAB	5,363,083	$ 174.87	$ -	$ 132.43	$ 0.31	$ 307.61	**5.79%**
1915(c) Waiver Enrollees	90,568	$ 4,806.19	$ -	$ -	$ 0.31	$ 4,806.51	**3.23%**
Total	**19,594,925**						
P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		**$ 83.80**	**$ -**	**$ 38.81**	**$ 0.31**	**$ 122.93**	**5.39%**
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**$ 81.36**	**$ -**	**$ 37.94**	**$ 0.31**	**$ 119.61**	**2.55%**
Total Projected Waiver Expenditures P2 (P2 MMs)						**$2,343,761,302**	

677,177,995.2
743,444,568.9
1,420,622,564

Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1 +P2)	R1	P2	Overall R1 to P2 Change (annualized)
MCHIP(Healthy Kids)	214,156			**7.68%**
TANF	27,106,159			**9.19%**
DAB	10,532,761			**5.14%**
1915(c) Waiver Enrollees	181,136			**3.66%**
Total	**38,034,211**			
P2 Weighted Average PMPM Casemix for R1 (R1 MMs)		**$ 111.74**	**$ 122.93**	**3.23%**
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		**$ 102.53**	**$ 119.61**	**5.27%**
Total Projected Waiver Expenditures P2 + P1 (Casemix for P1 and P2)				**$4,494,456,760**

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections: PMPM from previously approved waiver.

To modify the formulas as necessary to fit the length of the program, please ensure that Appendix D1 is completed entirely. The formulas will automatically update given this data.