

**Section 1915(b) Waiver
Proposal For Renewal of Michigan's
PIHP Programs for Specialty Services and
Supports for FY'08 and FY'09**

#MI 14.RO3

June 30, 2007

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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
- 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.
 - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
 - Section A is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - 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, 9, 10, 12, 23, 25, 27-48, 58, 62-84, 86, 89, 104, 108, 109, 110, 112-123; changes in bold font and yellow highlight
 - Section B is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Monitoring Plan from the previous waiver period.

X assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages: **pages 112-123, changes in bold font and yellow highlight.**

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective October 1, 2007 and ending September 30, 2009. (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 Patrick Barrie and can be reached by telephone at (517) 373-0196, or fax at (517) 373-3090, or e-mail at BarrieP@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 May 23, 2007. 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, 2007 through September 30, 2009**.

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 Psychoeducation). 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:

This waiver renewal request continues the program as specified in CMS requirements and regulations contained in the Balanced Budget Act for Managed Care. The program continues to be based on the values that reflect person-centered planning described above.

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. **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. **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. **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
- 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. **PIHP:** Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis.

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

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

___ The PAHP is paid on a risk basis.

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

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

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

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

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.

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 |

| County | Type of Program: PIHP | Name of PIHP |
|--|-----------------------|---|
| 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 | Pathways name changed to 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 |
| 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.

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

- ___ Mandatory enrollment
- ___ Voluntary enrollment

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

- ___ Mandatory enrollment
- ___ Voluntary enrollment

___ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- ___ Mandatory enrollment
- ___ Voluntary enrollment

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

- ___ Mandatory enrollment
- ___ Voluntary enrollment

___ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- ___ Mandatory enrollment
- ___ Voluntary enrollment

___ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- ___ Mandatory enrollment
- ___ Voluntary enrollment

___ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.

- ___ Mandatory enrollment
- ___ Voluntary enrollment

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.

___ **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.

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.

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):

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.**

- ___ 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.

**Summary of 1915(b)(3) Services Expenditures by Specialty
PIHP Waiver Program for the 12-Month Period January-December 2006**

(Source Data: data warehouse)

| Affiliation DBA | MH (b)(3) Pmts | SA (b)(3) Pmts | Total (b)(3) Pmts | % of Total |
|--------------------------------------|-------------------------|-----------------------|--------------------------|-------------------|
| Access Alliance of Michigan | 17,390,960.59 | 158,189.64 | 17,549,150.23 | 3.36% |
| CMH Affiliation of Mid-Michigan | 28,706,675.07 | 245,797.91 | 28,952,472.98 | 5.54% |
| CMH for Central Michigan | 13,488,544.51 | 119,906.35 | 13,608,450.86 | 2.60% |
| CMH Partnership of SW Michigan | 126,310,439.94 | 1,914,201.20 | 128,224,641.14 | 24.54% |
| CMHSA Network of West Michigan | 24,953,947.13 | 375,434.21 | 25,329,381.34 | 4.85% |
| Detroit Wayne County CMH Agency | 19,242,220.38 | 151,457.37 | 19,393,677.75 | 3.71% |
| Genesee County CMH Services | 10,177,943.18 | 86,646.32 | 10,264,589.50 | 1.96% |
| Lakeshore Behavioral Health Alliance | 42,209,455.29 | 342,126.14 | 42,551,581.43 | 8.14% |
| Lifeways | 29,385,694.66 | 247,187.87 | 29,632,882.53 | 5.67% |
| Macomb County CMH Services | 20,833,881.19 | 125,883.99 | 20,959,765.18 | 4.01% |
| Northcare | 11,400,499.63 | 119,819.81 | 11,520,319.44 | 2.20% |
| Northern Affiliation | 15,046,763.14 | 114,027.79 | 15,160,790.93 | 2.90% |
| Northern Lakes | 61,608,532.62 | 382,446.44 | 61,990,979.06 | 11.86% |
| Oakland County CMH Authority | 10,596,859.80 | 188,966.24 | 10,785,826.04 | 2.06% |
| Saginaw County CMH Authority | 21,704,638.98 | 196,542.89 | 21,901,181.87 | 4.19% |
| Southwest Alliance | 22,288,964.84 | 256,187.85 | 22,545,152.69 | 4.31% |
| Thumb Mental Health Alliance | 19,383,661.45 | 123,516.91 | 19,507,178.36 | 3.73% |
| Venture Behavioral Health | 22,487,171.41 | 235,571.31 | 22,722,742.72 | 4.35% |
| Grand Total | \$517,216,853.81 | 5,383,910.24 | \$522,600,764.05 | 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'08 and FY'09 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 **is appears to be** needed, the beneficiary, **with the help of the PIHP case manager or supports coordinator** 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, **if necessary, the beneficiary 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 accurately 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.

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):

- 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, 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.

Coverage includes **these models**:

- 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.**

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 in 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, or 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 **patient** roles **and identities**, 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. ~~For~~ Individuals who are functioning as Peer Support Specialists serving persons with mental illness, the Department may require **must meet MDCH** specialized training and/or certification, ~~as it deems necessary~~ **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:

- i. Staff and board of directors of the center is 100% primary consumers
- ii. PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program
- iii. PIHP facilitates consumers' ability to handle the finances of the program
- iv. The drop-in center is at a non-CMH site
- v. The drop-in center has applied for incorporation as a 501(c)(3) non-profit entity
- vi. There is a contract between the drop-in center and PIHP, or its subcontractor, identifying the roles and responsibilities of each party
- vii. 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.

10. 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:

~~Early childhood mental health professional (MA, MSW, Ph.D)~~ **Master's prepared early childhood mental health professional (licensed masters 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

~~Mental health therapist (BSW, MSW, or MA)~~ **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. ~~These services are provided by the adult recipient's mental health services coordinator and/or therapist employed by or under contract to the PIHP or its provider network.~~

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 masters 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:

Parent education is provided by a Child mental health professional who is trained in the model.

11. 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.

11. 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).

12.Support and Service Coordination: Functions performed by a supports coordinator, coordinator assistant, **case manager 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 **and case manager 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 ~~four~~ **three** possible options: targeted case management, supports coordinator, **case management assistant**, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator **or targeted case manager** must supervise the assistant. ~~When a case manager assistant is used, a qualified 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, ~~or case manager 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 assistant case manager~~ 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 ~~or case manager assistant~~) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant ~~or case manager 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, ~~case management 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.

- 13. 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.

14. Wraparound Services for Children and Adolescents

Wraparound services for children and adolescents is a highly individualized planning process performed by specialized **case managers 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 (~~T1016~~-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 ~~access standards contained in Section 12.1 of this Chapter, including~~ 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 medically 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. Sub-Acute Detoxification must be staffed 24 hours per day, seven days per week by a licensed physician or by the designated representative of a licensed physician.~~

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
 - ~~AAR service requirements found in Section 12.1 of this Chapter~~

- 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 intensive 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
 - ~~AAR service requirements found in Section 12.1 of this chapter~~
 - 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.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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.

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.

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.

| <i>Area(City/County/Region)</i> | <i>PCCM-to-Enrollee Ratio</i> |
|---------------------------------|-------------------------------|
| | |
| | |
| | |

| | |
|--|--|
| | |
| | |
| <i>Statewide Average: (e.g. 1:500 and 1:1,000)</i> | |

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. ___ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. ___ In accord with any applicable State quality assurance and utilization review standards.
- 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 and 2005. **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:

STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED
SPECIALTY SERVICES AND SUPPORTS

Revision 6/30/07

[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 **2006 External Quality Review** (EQR), and the **recommendations for improvement** from the Centers for Medicare and Medicaid Services (CMS) **2005** 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 subcontracting 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. **Seven PIHPs are currently CAs (an eighth PIHP will become a CA effective October 1, 2007).** CAs are not licensed or accredited for ongoing treatment services, but all of their subcontracting providers of outpatient, residential, intensive outpatient, sub-acute 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 &S 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.**

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 on-site the process, 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 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). 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 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 and includes substance abuse treatment services.
- b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to the problem. All other PIHPs choose a performance improvement project in consultation with the QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHPs 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 services identified in the plan of service, and billed, 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.a

IV. EXTERNAL QUALITY REVIEW

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the EQR for **an additional** two years, beginning June **2006**. HSAG worked with MDCH and representatives from the PIHPs to adapt the Year **Two and Three** review protocols for Michigan. The EQR consists of desk audits of PIHP documents and two-day on-site visits to each PIHP.

The contents of the review for Years One, Two and Three are:

- a. Validation of Performance improvement projects:
 - i. For FY'04, the EQR focused on the methods PIHPs employed to implement the MDCH-required project – Improvement of Coordination of Care with Primary Health Care Providers and the Medicaid Health Plans.
 - ii. **In FY 2005**, HSAG focused on correction of problems with methodology identified in year one.
 - iii. **In 2007, HSAG will review the methods PIHPs employ to implement the new MDCH-required project: improvement of timeliness of commencement of service following a face-to-face assessment with a professional. The standard is 95% of new consumers receive at least one on-going mental health or developmental disability service within 14 days following assessment.**
 - iv. **In 2008, HSAG will focus on correction of problems found in 2007.**
- b. Validation of performance indicators:
 - i. Year One the EQR looked at data collection methods and performed an ISCA.
 - ii. **In 2005** the EQR followed up on problems identified in Year One and validate performance indicators for the current period.
 - iii. **In 2007, the EQR will focus on all Medicaid performance indicators and especially those that MDCH constructs from encounter and quality improvement data sent to the state's data warehouse.**
 - iv. **In 2008, the EQR will follow up on problems identified in Year Three**
- c. Compliance with Michigan's Quality Standards per BBA:

- i. In the first year the EQR focused on 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
- ii. **In 2005, the EQR followed up on problems identified in Year One.**
- iii. In **2007** the EQR will address:
 1. Subcontracts and delegation
 2. Provider networks
 3. Access and availability
 4. Coordination of care and care management
 5. Psychiatric advanced directives
 6. Service authorization and appeals
 7. Credentialing
 8. Follow up on any areas found in need of improvement from the second review
- iv. **In 2008, the EQR will follow-up on problems identified in Year Three.**

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 all 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. Clinical Record Review

Reviews of clinical records to determine that person-centered planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and 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 team from encounter data in the MDCH warehouse. 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 might 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, 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, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews are conducted where consumers live for persons residing in group homes or persons living independently with intense and continuous in-home staff. Interviews of other consumers may be conducted in the PIHP office 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 composed of a minimum of six MDCH staff: **two** registered nurses, **a licensed master's social worker, an analyst, 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 the performance of the PIHPs. The specific Medicaid performance indicators (listed in Attachment A.III.1.b) 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 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. 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 Sub-element 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, 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 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 semi-annually. Sentinel events include, but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, suspected abuse and neglect of a recipient, incidents that involve arrest or conviction of the recipient, serious challenging behaviors (e.g., property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence) 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 is updated in the interim for 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 will report 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 will be 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 SURVEYS

The Michigan Legislature's Appropriations Act for MDCH requires that an annual survey of consumer satisfaction be conducted. For the past 12 years, MDCH has targeted a statewide probability sample of adult Medicaid beneficiaries who received mental health, developmental disabilities, or substance abuse treatment. The sample of consumers received a mailed copy of SAMHSA's Mental Health Statistical Improvement Program (MHSIP) consumer survey. Beginning in 2007, each PIHP will use the MHSIP questionnaire to survey adults with mental illness and children with serious emotional disturbance receiving certain covered services during each month of May. The Mental Health Quality Improvement Council has determined that adults receiving ACT and the families of children receiving home-based services will be surveyed in June 2007. In subsequent years, the adults and children in different programs will be surveyed each spring. Individual-level data is submitted to MDCH in August of each year where it will be analyzed

In 2007, MDCH be in its final year of a three-year Data Infrastructure Grant (DIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to prepare Michigan's community mental health agencies for the systematic, on-going measurement of outcomes for adults with mental illness and the use of these outcome measurements for managing the treatments, services, and supports provided to consumers. The initiative represents a response both to national trends and to concerns expressed by the Governor's Commission on Mental Health, the MDCH QIC, and the Evidence-based Practice Steering Committee that Michigan does not, on a statewide basis, evaluate the outcomes of care as part of its overall quality management strategy.

This addition to the quality assessment initiative will allow the State to provide convincing evidence to important stakeholders that public mental health services are helpful to consumers and their families. It also will provide our treatment professionals at the local level important information that can inform clinical judgment and help improve the quality of publicly provided mental health care.

The final year of the grant will focus on implementation strategies for the OQ45.2 measure selected in 2006. In particular, the instrument will be pilot-tested along with a recovery-oriented, individual-level measure. At the end of the testing period, a determination will be made about whether and how to proceed on a statewide basis.

IX. MENTAL HEALTH SYSTEMS TRANSFORMATION

- a. MH&SA 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. MH&SA is promoting the development or enhancements of local PIHP and subcontractor organizational cultures that adopt evidence-based practices (EBPs), and evaluate and continuously improve existing practices.
- b. A steering committee of MH&SA staff, mental health consumers, and representatives from the PIHPs, major state universities, and mental health advocacy organizations determined that PIHPs would be required to implement either Family Psycho-Education (FPE) or Integrated **Dual Diagnosis** Treatment for Co-Occurring Disorders (IDDT) in 2005-07 **using the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recognized models. Federal** Mental Health Block Grant funds **were** provided to each PIHP to initiate their **EBP** projects **and to assist with** community organizing and staff training. **Block Grant funds have also been set aside for training for each EBP. For FY'2008, federal Mental Health Block Grant funds will again be available to assist PIHPs to implement one of the two practices not yet implemented in FY'2005-2007, or if they are implementing both FPE and IDDT, to implement supported employment. It is intended that all PIHPs have both FPE and IDDT available for beneficiaries who choose them by October 1, 2008.** Universities are assisting with evaluation of the **implementation** projects. Fidelity to the models will be monitored by MDCH.
- c. **Some** PIHPs are also implementing Parent Management Training.
- d. MH&SA 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 third 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.

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.

PIHPs 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 May 2005 by the Quality Improvement Council**

1. The percent of ~~persons~~ **children and adults** receiving a pre-admission screening for psychiatric inpatient care for whom the disposition (decision) was completed within three hours ~~for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities.~~ Standard = 95% of decisions are made within three hours.
2. The percent of **new** persons receiving a face-to-face **meeting assessment** with a professional ~~for the purposes of screening, assessment or services~~ within 14 calendar days of a non-emergency request for service from MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% of persons receive a face-to-face meeting within 14 calendar days.
3. The percent of **new** persons starting any needed on-going service within 14 calendar days of a non-emergent assessment with a professional for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% of persons receive at least one service within 14 calendar days of the assessment.
4.
 - a. The percent of ~~persons~~ **discharges** from a psychiatric inpatient unit who are seen for follow-up care within seven days for MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders. Standard = 95% are seen for follow-up care within seven days.
 - b. **The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days.**
5. The percent of total Medicaid recipients receiving PIHP managed mental health services by PIHP by population: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and **adults and children** with substance use disorders.
6. The percent of Habilitation Supports Waiver enrollees **during the quarter with encounters in data warehouse** who are receiving at least one **HSW service per month in addition to** ~~additional service besides~~ supports coordination ~~each month.~~
7. The percent of total annual Medicaid expenditures spent on managed care administrative **functions** for PIHPs.

8. The percent of adults with mental illness and **percent of** adults with developmental disabilities **served by PIHPs who are** in competitive employment ~~during the year~~.
9. The percent of adults with mental illness and **percent of** adults with developmental disabilities **served by the PIHPs** who earned minimum wage or more from employment activities (**competitive, supported or self employment, or sheltered workshop**).
10. The percent of ~~persons~~ **children and adults** readmitted to a psychiatric inpatient unit within 30 days of discharge from a psychiatric inpatient unit. Standard = 15% or less are readmitted. Population covered: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities.
11. The number of substantiated recipient rights complaints per thousand persons served annually in the categories of Abuse I and II and Neglect I and II. Population covered: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities.
12. The **semi-annual** number of sentinel events per thousand **Medicaid beneficiaries** ~~persons served annually~~. Population covered: MI adults, children with SED, adults with developmental disabilities, and children with developmental disabilities, and persons with substance use disorders.

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 will be 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.** PIHP informational documents that are made available to the public are subject to MDCH review during its regular site visits to PIHPs.

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 must 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.

PIHP services are voluntary (unless court-orders on an involuntary basis). There is no enrollment process for this Waiver. Beneficiaries who need the specialty services that are provided under this Waiver, and who meet clinical eligibility criteria, must obtain 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.

___ 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 are not "enrolled" in a PIHP. Therefore, they do not "dis-enroll" either. 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.
- 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

- 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).
- The State’s timeframe within which an enrollee must file a **grievance** is 60 days.

c. Special Needs

- 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 nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be 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 one 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 Adequacy Assurance by | | | | | | | | | | | | |

| 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 |
| 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 Review | | | | | | | | | | | |
| Other: (describe) | | | | | | | | | | | |
| EQR 2004 | | | | √ | √ | | | | √ | | √ |

| 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 |
| EQR 2005 | | | | | | | √ | | √ | | √ | |
| EQR 2006 | | | | √ | √ | | | √ | | | | |
| EQR 2007-08 | √ | √ | | | | | | | | √ | √ | |
| Application for Participation 2002 | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Service Agency Profiles | | | | | | | | √ | | | √ | |

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

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

Each PIHP must be a CMHSP 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. The site review portion of the certification process may be waived if the PIHP is accredited by JCAHO, CARF, or COA.

- c. Consumer Self-Report data

- CAHPS (please identify which one(s))
 State-developed survey
 Disenrollment survey

Consumer/beneficiary focus groups

Other: 1. SAMHSA's Mental Health Statistical Improvement Program consumer satisfaction survey is used annually by PIHPs for a convenience sample of adult beneficiaries with serious mental illness and families of child beneficiaries with serious emotional disturbance in MDCH-selected programs.

2. MDCH site review staff annually conduct face-to-face interviews of at least 1,800 Medicaid beneficiaries about the Specialty Services program. The interview questionnaire was provided as part of the response to the 2007 pre-renewal CMS information request.

d. Data Analysis (non-claims)

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

Grievances and appeals data

The data on beneficiary appeals, requests for Fair Hearing and their disposition are collected from the Administrative Tribunal which conducts the Medicaid Fair Hearings by the Division of Quality Management and Planning where it is analyzed by program type (1915 b and c), population (mental health, developmental disabilities, and substance abuse) and PIHP. PIHPs are 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

Other (please describe)

Sentinel events: PIHPs report semi-annually 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 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 Sub-element 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 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
- m. X Performance Improvement projects [**Required** for MCO/PIHP]
 - _____ Clinical
 - _____ Non-clinical

The PIHP's are visited annually by a MDCH team of clinicians, analysts and consumers using a site review protocol (sent to CMS RO during Spring 2005 site visit activities). The site review consists of a review of administrative policies and procedures, clinical record review of a sample of beneficiaries, and interviews with a sample of beneficiaries using a standard questionnaire. The result of the on-site review is a report issued to the PIHP and an expectation of a plan of correction back. MDCH team revisits within six months to assure progress is being made in the implementation of the plan of correction.

- m. Performance Improvement projects [**Required** for MCO/PIHP]
 Clinical
 Non-clinical
Two projects per waiver period are required of the PIHPs. One project during the past waiver period was mandatory for all PIHPs: coordination of care with primary care providers including the Medicaid health plans. **The project for FY07-08 is for PIHPs to improve the timeliness of access to the first service following an assessment by a professional of a newly-enrolled beneficiary.** Reports on the progress of the projects are submitted to MDCH semi-annually.
- n. Performance measures [**Required** for MCO/PIHP]
 Process
 Health status/outcomes
 Access/availability of care
 Use of services/utilization
 Health plan stability/financial/cost of care
 Health plan/provider characteristics
 Beneficiary characteristics
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 may be 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. Other: (please describe)
 a. External quality review. In year one of the review (2004-05 for the period October 1, 2003 to September 30, 2004) Health Services Advisory Group (HSAG) performed a review of compliance with the BBA standards for Program Integrity, Information to Beneficiaries, Coverage and Authorization, and Quality of Care. The review included a desk audit of PIHP policies and procedures and an on-site visit. During the next two years, the review will focus on plans of correction, and

Timely Access, Coordination and Continuity of Care, Provider Selection, Program Integrity, Information to Beneficiaries and Provider Capacity.

- 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 tri-ennially, 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 or certification 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.

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously, 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:

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:

Yes

No. Please explain:

1.Summary of Results of Consumer Interviews Conducted by MDCH Staff

The site review team conducted approximately 1,200 interviews with consumers and/or family members during the last review cycle completed in 2005-07. 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 frequently corroborate findings noted in clinical record reviews. For example, generally a high percentage of consumers confirm they were able to select whom they wished to participate in their person-centered planning meeting, but a lower percentage had an understanding of independent facilitation or report being able to pick who will facilitate their meeting. Some of the identified issues, such as choice of staff and staff turnover, the opportunity of individuals to develop a crisis plan, and satisfaction with individual clinicians and physicians can vary widely according to PIHP and program site. Other issues, such as the desire for more respite services, and the low percentage of consumers who report having seen results of consumer satisfaction surveys seems to be more widespread. Overall, interview results show that a high percentage of individuals are satisfied with the services provided through the PIHP and the staff members who provide them.

Problems Identified

See above.

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 Conducted by Contractor

From 1997 to 2005, the Michigan Department of Community Health contracted with private-sector vendors to conduct separate statewide consumer satisfaction surveys of adult Medicaid beneficiaries with (1) mental illness, (2) developmental disabilities, and (3) substance use disorders. Employing mail survey methods with probability samples drawn from each subpopulation, satisfaction was measured using the 28-item Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. This instrument asks beneficiaries to rate their care experience in five areas: general satisfaction, access to services, quality and appropriateness, participation in treatment planning, and outcomes.

Problems identified

During the 9-year period when these surveys were implemented, response rates remained consistently low, ranging on average between 20 and 25 percent. Survey results also remained extraordinarily stable, with all subscales except "outcomes" achieving 80% agreement or higher in each annual administration. By comparison, the average percentage in agreement for the outcomes domain stayed steady at approximately 70 percent.

Corrective action (plan/provider level)

N/A

Program change (system-wide level)

As a result of a recommendation made by its Quality Improvement Council, the Michigan Department of Community Health decided in 2006 to redesign its approach to the measurement of consumer satisfaction in a way that would better promote improvement at the program and agency levels. This change in strategy reflected feedback from the state's 18 PIHPs that statewide satisfaction results provided little guidance for local quality improvement efforts. The redesigned measurement strategy focuses on selected programs within the PIHPs. In (June) 2007, all beneficiaries enrolled in Assertive Community Treatment (ACT) will be asked to complete the 28-item MHSIP Consumer Survey. In addition, all families with a child or adolescent receiving home-based services will be asked to complete the 26-item Youth Satisfaction Survey (YSS) for Families. De-identified raw data will be submitted for scoring to MDCH and will be reported at the program, agency, and state levels. It is expected that different programs within the PIHPs will be selected each year.

Strategy: Data analysis

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

1. Denials of Referral Requests Data Summary of Results

As noted in the previous Waiver renewal application, MDCH revised its Program Policy Guidelines (PPG) in order to 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 first data received using this methodology showed that approximately 86% of Medicaid eligible beneficiaries who telephoned in, or walked in for a screening, were determined to be eligible for services. About 6% of those who telephoned or walked in requested help with non-mental health related services. Nearly all of the individuals denied eligibility were 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 increased from 254 in fiscal year 2005 to 306 in fiscal year 2006. A summary of Fair Hearing data, as well as a breakdown by PIHP and types of issues raised in the Fair Hearing requests were shared with CMS during their pre-waiver renewal site visit to MDCH.

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 are settled before getting to a hearing or are dismissed at the hearing. In Fiscal Year 2006, only 72 of the 306 Fair Hearing requests actually resulted in a formal hearing. Of those 72, the PIHP's decision was upheld 58 times and decisions in favor of the beneficiary occurred 14 times.

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. In addition, as discussed during the on-site, pre-waiver renewal site visit by CMS staff, the Department requires all arrests and convictions to be reported as sentinel events, which tends to inflate the sentinel event rates for certain PIHPs.

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.

During the recent on-site CMS visit there was some discussion on MDCH's use of the sentinel event data collection process to also capture information on all arrests and convictions. MDCH will continue to track all arrests and convictions for those populations on which sentinel event reporting is required, but intends to remove those events from future sentinel event reports.

4. Timely Access

Summary of Results

For FY'06 the annual average mean score on the first timeliness indicator, time between presentation for inpatient screening to disposition regarding inpatient admission, showed annual average mean scores of 97.36% for adults and 98.02%

for children. On the second indicator, time between first request and initial assessment (standard is 95% within fourteen days), the average annual score was 95.60% for all populations. There was slight variation between populations with mean scores of 96.23% for SED children, 96.84% for adults with mental illness, 98.18% for children with a developmental disability, 97.19% for adults with a developmental disability, and 92.95% 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 93.62%. The standard was not met for any of the populations with an average score of 92.24% for SED children, 93.92% for adults with mental illness, 88.39% for children with a developmental disability, 87.55% for adults with a developmental disability, and 94.67% for individuals with a substance abuse disorder.

Problems identified

For the first indicator noted above, there were no systemic issues. However two individual affiliates had difficulty meeting the standard (95% within 3 hours) over the year for both adults and children (Detroit and Lifeways). On the second indicator, 14 days between first request for service and assessment, thirteen PIHPs met the standard for at least four of the five populations. Six PIHPs met the standard for all five of the populations. For the third indicator, only three PIHPs met the standard for at least four of the five populations. Only two PIHPs, Northern Affiliation and Thumb Alliance met the standard for all five populations.

Corrective action

Based on results from the Performance Indicators, MDCH will follow up with contract performance objectives for FY'07.

Program Change

Due to problems noted with results from the third indicator, the Quality Improvement Council decided to select time between assessment and first service as the topic for the Year 3 Performance Improvement Project as part of the External Quality Review.

Strategy: Network adequacy

Confirmation it was conducted as described:

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:

Yes

No. Please explain:

Summary of Results

During the 2005-2007 review cycle, MDCH site review teams reviewed policies, procedures and 3,073 individual clinical records against a standard set of protocols. Using standardized sets of questions, the team members also interviewed 1,230 consumers. [Note: site review protocols were shared with CMS during its pre-waiver renewal site visit.] For the most part, the PIHPs demonstrated modest improvement in complying with MDCH's site review standards.

Problems Identified

A summary of PIHP site review performance (Fingertip Report: Table C) was shared with CMS staff members during its pre-waiver renewal site visit. 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:

Yes

No. Please explain

Summary of Results

Each PIHP was required to implement at least two performance improvement projects (PIP). The topic of the first project was selected by MDCH, for 16 of the 18 PIHPs. This topic was improving the timeliness of access to care for the lowest scoring population (children with serious emotional disturbance, adults with mental illness, children with developmental disabilities, adults with developmental disabilities, or persons with substance use disorders) where the PIHP's averaged performance for the first three quarters of FY'06 failed to meet the 95% standard for starting an on-going service within 14 days of non-emergent assessment. The topic was selected on recommendations from MDCH's Quality Improvement Committee. The two PIHPs that met this performance indicator standard for all populations served were allowed to select the topic for their first PIP. All of the PIHPs, in conjunction with their own Quality Improvement Advisory Committees, were allowed to select the focus of their second mandated project. Topics for these second projects included: improving psychiatric inpatient readmission rates; family psycho-education improvement; improving screening and integrated treatment for co-occurring disorders; and improving access to care. The first reports on these projects were submitted in January 2007. Second reports will be due in July 2007.

The first PIP was also the project subjected to External Quality Review performance improvement project validation activities.

Problems Identified

A review of the submitted reports, as well as EQR validation activities on PIP #1 have demonstrated marked improvement in the design, implementation, and outcomes of these PIPs. In the most recent round of EQR validation assessments, preliminary reports validated 13 PIHP's PIPs, 3 were partially met, and 2 were not validated. This performance was improved from the previous year where 8 PIHP's PIPs were validated, 6 were partially validated, and 4 were not validated.

Corrective action

During the last 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, submit, 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:

Yes

No. Please explain:

For FY'06 HSAG validated nine mental health performance indicators and one substance abuse indicators for each PIHP. [Note: CMS has received the final report on the EQR for Year 2] HSAG conducted this evaluation 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 2, fourteen PIHPs were either fully valid or substantially valid on all ten indicators. Two PIHPs were fully or substantially valid on all but one indicator. The remaining two PIHPs were evaluated as 'not valid' on two 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 all ten indicators. 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.

Problems identified

HSAG recommended that two of PIHPs with indicators evaluated as 'not valid' should improve oversight of data reported by affiliates and coordinating agencies in regard to establishment of policies and procedures, thorough documentation of oversight activities, and development of multidisciplinary teams for oversight of performance indicator. HSAG recommended that one PIHP improve their audit process of manual data entry.

Corrective action (plan/provider level)

Each PIHP received their evaluation during the Fall FY06. HSAG will review their progress during the FY'07 EQR process.

Program change (system-wide level)

FY06 is the first year that MDCH has implemented the performance indicators that were revised in coordination with the 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 for 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:

Yes

No. Please explain:

Summary of results

External Quality Review. In Year One of the review (2004-05 for the period October 1, 2003 to September 30, 2005) HSAG performed a review of compliance with the BBA standards in eight areas: Quality Assessment & Performance Improvement Plan and Structure, Performance Measurement and Improvement, Practice Guidelines, Staff Qualification and Training, Utilization Management, Customer Service, Recipient Grievance Process, and Recipient Rights and Protections. Based upon Year 1 results, HSAG and MDCH developed a follow-up process to address those specific standards that were found to be less than fully compliant during Year 1. The review included a desk audit of PIHP policies and procedures and an on-site visit. HSAG rated each standard as to whether the corrective action was sufficient to attain compliance. The PIHP's score on each standard was calculated as a percentage of the total number of standards elements found to be in compliance.

During the Year Two activities, eleven PIHPs received scores of 90 percent and above on all eight standards. Two PIHPs scored at least a 90 percent on all but one standard. Four PIHPs scored at least a 90 percent on all but two or three standards. The remaining PIHP had scores below 90 percent for five of the standards. Of the scores below 90 percent, 10 (59% percent) were below 80%. The lowest score was 62%. These results are a substantial improvement from the Year 1 results during which only one PIHP received scores of 90% or above for all eight standards and the lowest score was 8%. (Note: HSAG had to re-analyze Year One results in order to make comparisons with Year Two performance.)

Year Three EQRO activities focused on Timely Access, Coordination and Continuity of Care, Provider Selection, Program Integrity, Information to Beneficiaries and Provider Capacity. Many of the PIHPs have already received individual reports and HSAG is scheduled to provide MDCH with the 2006-2007 External Quality Review Technical Report by October 1, 2007.

Problems identified

As described above, PIHPs generally demonstrated substantial improvements from Year One to Year Two. In some instances however, corrective actions the PIHPs were to take had not yet been fully implemented, or had not achieved the desired results at the time of HSAG's Year Two review. Typically, these areas varied by PIHP. MDCH site review staff routinely addressed PIHP progress on implementing these corrective actions during any subsequent site review activity.

Corrective action (plan/provider level)

Year Four activities will include review and correction of those problem areas identified during Year Three. HSAG and MDCH will work together to develop and implement follow-up review processes that reinforce and complement their respective oversight activities. Any PIHP that received a score of less than Fully Compliant will be required to submit a plan of correction to MDCH. HSAG will assess PIHP compliance and effectiveness of the plan of correction during Year 4

EQRO activities, and MDCH will also review the PIHP's implementation of the plans of correction during its own site review activities.

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

Strategy: Application for Participation

Confirmation it was conducted as described:

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 process 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:

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

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
 - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

- Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
Nick Lyon
- c. Telephone Number: 517-241-1193
- d. E-mail: LyonN2@michigan.gov
- e. The State is choosing to report waiver expenditures based on
 date of payment.
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

- B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.
Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.
- a. The State provides additional services under 1915(b)(3) authority.
- b. The State makes enhanced payments to contractors or providers.
- c. The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

- a. ___ MCO
- b. X PIHP
- c. ___ PAHP
- d. ___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers Not Applicable To This Waiver

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a. ___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 - 1. ___ First Year: \$___ per member per month fee
 - 2. ___ Second Year: \$___ per member per month fee
 - 3. ___ Third Year: \$___ per member per month fee
 - 4. ___ Fourth Year: \$___ per member per month fee
- b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ___ Other reimbursement method/amount. \$___ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: **Not Applicable To This Waiver**

- a. ___ Population in the base year data
 - 1. ___ Base year data is from the same population as to be included in the waiver.
 - 2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. ___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

- d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____
- e. ___ [Required] List the year(s) being used by the State as a base year: _____. If multiple years are being used, please explain: _____
- f. ___ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. ___ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. ___ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: **The actual R1 to R2 and the projected R2 to P2 increase in member months is attributable to growth in Medicaid eligibles, which are the “covered lives” under the waiver program. This growth is due to the continued decline of the state’s economy,** with its related workforce downsizing, loss of

private insurance, etc., and in part due to the state’s enhanced Medicaid information and outreach efforts.

- d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2: **The R1 [SFY 06] to R2 [SFY 07] drop in MCHIP member months is due to the State’s implementing CMS-required enhancements to the MCHIP eligibility coding protocols.**
- e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: SFY.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers: **Not Applicable To This Waiver**

- a. ___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

- a. ___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:
- b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: No Managed Specialty services or supports are excluded from the CE analysis. Each 1915(b) waiver reports on separate CMS 64.9 Waiver forms and separate lines of the Waiver summary forms.

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers: **Not Applicable To This Waiver**

For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

| Additional Administration Expense | Savings projected in | Inflation projected | Amount projected to be spent in Prospective |
|-----------------------------------|----------------------|---------------------|---|
|-----------------------------------|----------------------|---------------------|---|

| | State Plan Services | | Period |
|--------------------------|---|--|---|
| <i>(Service Example:</i> | | | |
| Total | <i>Appendix D5 should reflect this.</i> | | <i>Appendix D5 should reflect this.</i> |

The allocation method for either initial or renewal waivers is explained below:

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. ___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. X Other (Please explain). There is NO FEE FOR SERVICE coverage for any of the benefits covered under the managed specialty services and supports program. The state administrative costs included in Appendix D2.A are limited to MMIS, MDCH/State staffing (CAP), External Quality Review, Pre-Admission Screening and Resident Review Activities, fees for claims and rebates processing and DUR for the fee for service psycho-pharmaceutical benefits “impacted” by PIHPs contracted under this waiver, Consumer/Beneficiary Satisfaction surveys, consumer involvement on quality review teams*, and professional contracts associated with the administration of the specialty managed care program. All administrative costs have been allocated to the managed care MEGs listed herein on a PMPM basis. *These consumers were hired as state employees in FY 06 Q2.

H. Appendix D3 – Actual Waiver Cost

- a. X The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

In addition to Michigan using a portion of its waiver savings to fund the additional 1915(b)(3) services listed in Appendix D2.S, Michigan’s contract with the PIHPs under this program allows the PIHPs to use savings (unexpended capitation payments) from one year to fund the implementation of an approved reinvestment strategy in the year following cost settlement. Under the shared risk provisions of this contract, the PIHP may retain unexpended Medicaid capitation funds up to 7.5% of the Medicaid pre-payment authorization. All Medicaid savings funds must be expended within one fiscal year following CMS approval of the reinvestment plan. In the event that a final MDCH audit report creates new Medicaid savings, the PIHP will have one year following

the date of the final audit report to expend those funds in accordance with the PIHP contract's reinvestment strategy requirements outlined below.

PIHP Contract Reinvestment Strategy requirements [from Section 7.7.2.2]:

- A. Development of new treatment, support and/or service models; these shall be additional 1915(b)(3) services to Medicaid beneficiaries as allowed under the cost savings aspect of the waiver;
- B. Expansion or continuation of existing state plan or 1915(b)(3) approved treatment, support and/or service models to address projected demand increases;
- C. Community education, prevention and/or early intervention initiatives;
- D. Treatment, support and/or service model research and evaluation;
- E. The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and/or developments to: (1) assist the PIHP (as a PIHP) to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities; (2) implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation; or (3) initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions;
- F. Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted benefits under conditions of changing economic conditions and payment modifications. This enables the PIHP to utilize savings to assure the availability of benefits in the following year.

The reinvestment strategy becomes a contractual performance objective. The PIHP shall document for audit purposes the expenditures that implement the reinvestment plan. Unexpended Medicaid savings shall be returned to the MDCH as part of the year-end settlement process. MDCH will return the federal share of the unexpended savings to CMS.

For an initial waiver, **NA To This Waiver** in the chart below, please document the amount of savings that will be accrued in the State Plan

services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

| 1915(b)(3) Service | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|--------------------------|--|---------------------|--|
| <i>(Service Example:</i> | | | |
| Total | | | |

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

| 1915(b)(3) Service | Amount Spent in Retrospective Period | Inflation Projected* | Amount projected to be spent in Prospective Period* |
|---|---|--|--|
| <i>Individualized Specialty MH & SA Services (Inclusive of the PIHP Reinvestment Strategy Funding):</i> | \$521,345,279 in R1 and \$269,957,089 through Q2 in R2, totaling \$791,302,368 From Appendix D.3 | 2.4% yr R2 to P1; 1.9% P1 to P2 | \$562,353,822 in P1 and \$582,121,644 in P2, for a P1 & P2 total of \$1,144,475,466 |
| Total | (PMPM in Appendix D3 Column H x member months | | (PMPM in Appendix D5 Column W x projected member months should |

| | | | |
|--|--------------------|--|-------------|
| | should correspond) | | correspond) |
|--|--------------------|--|-------------|

- b. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- c. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
- The state requires the PIHPs to demonstrate financial risk protections sufficient to cover the PIHP's determination of risk. To this end, the State allows PIHPs to use one or a combination of measures including pledged assets, stop loss insurance, and "Internal Service Funds."

Basis and Method:

1. X The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately.
- The state requires the PIHPs to demonstrate financial risk protections sufficient to cover the PIHP's determination of risk. No adjustment was necessary.
2. ___ The State provides stop/loss protection (please describe):
- d. **NA To This Waiver** Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:
1. ___ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
- i. Document the criteria for awarding the incentive payments.

- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2. _____ For the fee-for-service portion of the waiver [**There is no fee-for-service portion of this waiver**], all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
- i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint: NA To This Waiver
I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, **skip to J @ page 77 of 84 of the entire preprint, page 22/31 of this Section D excerpt!**. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are

not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ____ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.
 - i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.
- b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For

example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
 - Reductions in State Plan Services (-)
 - Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)
1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
 2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ *Determine adjustment for Medicare Part D dual eligibles.*
 - E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe): For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - iv. ___ Changes in legislation (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. ___ **Administrative Cost Adjustment***: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

- 1. ___ No adjustment was necessary and no change is anticipated.
- 2. ___ An administrative adjustment was made.
 - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
 - ii. ___ FFS cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):

- iii. ____ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
- A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1. ____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2. ____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.
1. ___ We assure CMS that GME payments are included from base year data.
 2. ___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
 3. ___ Other (please describe):
- If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.
1. ___ GME adjustment was made.
 - i. ___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
 2. ___ No adjustment was necessary and no change is anticipated.
- Method:*
1. ___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
 2. ___ Determine GME adjustment based on a pending SPA.
 3. ___ Determine GME adjustment based on currently approved GME SPA.
 4. ___ Other (please describe):
- g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.
1. ___ Payments outside of the MMIS were made. Those payments include (please describe):

2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. ___ The State had no recoupments/payments outside of the MMIS.

- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine copayment adjustment based on pending SPA.
3. ___ Determine copayment adjustment based on currently approved copayment SPA.
4. ___ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ___ No adjustment was necessary
2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ___ The State made this adjustment:*

- i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5**.
 - ii. ___ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

 - 1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population, *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
 - 2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor’s providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
 - 3. ___ Other (please describe):

- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under “Other” including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
 - 1. ___ We assure CMS that DSH payments are excluded from base year data.
 - 2. ___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
 - 3. ___ Other (please describe):

- l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely

to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. ___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
 2. ___ This adjustment was made:
 - a. ___ Potential Selection bias was measured in the following manner:
 - b. ___ The base year costs were adjusted in the following manner:
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
1. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
 2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
 3. ___ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
 4. ___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated**

waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments. When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

| Adjustment | Capitated Program | PCCM Program |
|---------------------------|--|--|
| Administrative Adjustment | The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column) | The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness). |

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.

1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 3. ___ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees.

The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.

1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. ___ This adjustment was made in the following manner:

- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1]. **The trend rates for the Base Year (R2) to the first projection year (P1) were primarily developed from a comparison of the projected actuarially sound capitation rates for P1 to the current actuarially sound capitation rates. The updated actuarially sound capitation rates were developed from a rate base using fiscal years 2005 and 2006 encounter experience, and corresponding Medicaid Utilization Net Cost reports. Trend rates to project the fiscal year 2005 and 2006 experience forward to P1 (fiscal year 2008) were developed based on the observed historical experience, with adjustments to normalize for changes in geographic and age/gender mix.**

Additionally, a pharmacy trend was applied to the fee-for-service component of the MCHIP, TANF and DAB experience. The pharmacy trend load is 12.5%. The blended trends for State Plan Services are listed in the following table.

| Population / Service Category | State Plan Services |
|-------------------------------|---------------------|
| MCHIP (Healthy Kids) | 18.3% |
| TANF | 11.3% |
| DAB | 3.3% |
| Waiver (c) | 2.4% |

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

- i. State historical cost increases. Please indicate the years on which the rates are based: base years: _____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost-increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. **The trend rate for the capitation component of the waiver was developed from the trend required to maintain actuarially sound capitation rates. The pharmacy component of the waiver reflects national pharmaceutical trends.**
 - ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.
- b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. An adjustment was necessary and is listed and described below:

i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. Determine adjustment for Medicare Part D dual eligibles.

E. Other (please describe):

ii. The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv. Changes brought about by legal action (please describe):

For each change, please report the following:

A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

- B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
- D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. X **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

- 1. ___ No adjustment was necessary and no change is anticipated.
- 2. X An administrative adjustment was made.
 - i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - ii. X Cost increases were accounted for.

- A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
- B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
- D. Other (please describe): **A completion factor was applied to the R2 PMPM to reflect known full year Administration costs for P1. A base inflation rate of 6.2%, which is consistent with the state's inflation experience administering Michigan's Medicaid Health Plans, was applied to take R2 to P1 and P1 to P2; both are reflected in the inflation adjustment Column [Col. Y] of Appendix D5.**

- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1; The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: **The trend rates for the Base Year (R2) to the first projection year (P1) were primarily developed from a comparison of the projected actuarially sound capitation rates for P1 to the current actuarially sound capitation rates. The updated actuarially sound capitation rates were developed from a rate base using fiscal years 2005 and 2006 encounter experience, and corresponding Medicaid Utilization Net Cost reports. Trend rates to project the fiscal year 2005 and 2006 experience forward to P1 (fiscal year 2008) were developed based on the observed historical experience, with adjustments to normalize for changes in geographic and age/gender mix.**

| Population / Service Category | B(3) Services |
|-------------------------------|----------------|
| MCHIP (Healthy Kids) | 8.2% |
| TANF | 9.3% |
| DAB | 1.6% |
| Waiver (c) | Not Applicable |

2. X [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

- i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years: **See discussion at J.d.1 above.**
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
- ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from Section D.I.J.a. above: **The trend rates for the Base Year (R2) to the first projection year (P1) were primarily developed from a comparison of the projected actuarially sound capitation rates for P1 to the current actuarially sound capitation rates. The updated actuarially sound capitation rates were developed from a rate base using fiscal years 2005 and 2006 encounter experience, and corresponding Medicaid Utilization Net Cost reports. Trend rates to project the fiscal year 2005 and 2006 experience forward to P1 (fiscal year 2008) were developed based on the observed historical**

experience, with adjustments to normalize for changes in geographic and age/gender mix. Additionally, a pharmacy trend was applied to the fee-for-service component of the MCHIP, TANF and DAB experience. The pharmacy trend load is 12.5%. The blended trends for State Plan Services are listed in the following table.

| Population / Service Category | State Plan Services | B(3) Services |
|-------------------------------|---------------------|----------------|
| MCHIP (Healthy Kids) | 18.3% | 8.2% |
| TANF | 11.3% | 9.3% |
| DAB | 3.3% | 1.6% |
| Waiver (c) | 2.4% | Not Applicable |

- e. **Incentives (not in capitated payment) Trend Adjustment: NA To This Waiver**
Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**.
 3. _____ Explain any differences:
- f. **Other Adjustments** including but not limited to federal government changes. (Please describe):
- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
 - Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 - **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
- Basis and Method:*

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. Other (please describe):
 1. No adjustment was made. **Base year is net of rebates.**
 2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**: **The actual R1 to R2 and the projected R2 to P2 increase in member months is attributable to growth in Medicaid eligibles, which are the “covered lives” under the waiver program. This growth is due in part to growth in overall state population, in part due to the continued decline of the state’s economy, with its related workforce downsizing, loss of private insurance, etc., and in part due to the state’s enhanced Medicaid information and outreach efforts. The R1 [SFY 06] to R2 [SFY 07] drop in MCHIP member months is due to the State’s implementing CMS-required enhancements to the MCHIP eligibility coding protocols.**
 2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State’s explanation of cost increase given in **Section D.I.I and D.I.J**: **The trend rates for the Base Year (R2) to the first**

projection year (P1) were primarily developed from a comparison of the projected actuarially sound capitation rates for P1 to the current actuarially sound capitation rates. The updated actuarially sound capitation rates were developed from a rate base using fiscal years 2005 and 2006 encounter experience, and corresponding Medicaid Utilization Net Cost reports. Trend rates to project the fiscal year 2005 and 2006 experience forward to P1 (fiscal year 2008) were developed based on the observed historical experience, with adjustments to normalize for changes in geographic and age/gender mix.

Additionally, a pharmacy trend was applied to the fee-for-service component of the MCHIP, TANF and DAB experience. The pharmacy trend load is 12.5%. The blended trends for State Plan Services are listed in the following table.

| Population / Service Category | State Plan Services | B(3) Services |
|-------------------------------|---------------------|----------------|
| MCHIP (Healthy Kids) | 18.3% | 8.2% |
| TANF | 11.3% | 9.3% |
| DAB | 3.3% | 1.6% |
| Waiver (c) | 2.4% | Not Applicable |

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State’s explanation of utilization given in **Section D.I.I and D.I.J**: [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1]. The actual trend rate used is: **The trend rates for the Base Year (R2) to the first projection year (P1) were primarily developed from a comparison of the projected actuarially sound capitation rates for P1 to the current actuarially sound capitation rates. The updated actuarially sound capitation rates were developed from a rate base using fiscal years 2005 and 2006 encounter experience, and corresponding Medicaid Utilization Net Cost reports. Trend rates to project the fiscal year 2005 and 2006 experience forward to P1 (fiscal year 2008) were developed based on the observed historical experience, with adjustments to normalize for changes in geographic and age/gender mix.**

Additionally, a pharmacy trend was applied to the fee-for-service component of the MCHIP, TANF and DAB experience. The pharmacy trend load is 12.5%. The blended trends for State Plan Services are listed in the following table.

| Population / Service Category | State Plan Services | B(3) Services |
|-------------------------------|---------------------|----------------|
| MCHIP (Healthy Kids) | 18.3% | 8.2% |
| TANF | 11.3% | 9.3% |
| DAB | 3.3% | 1.6% |
| Waiver (c) | 2.4% | Not Applicable |

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Row # /
Column
Letter

B C D E F G H I J K L M N

State of Michigan HMO Renewal Waiver
Estimated Member Month Calculations

State: Michigan

Actual Enrollment for the Time Period - R1 = 7/1/2005 through 6/30/2006 R2 = 7/1/2006 through 12/31/2006 **R1 and R2 include actual data and dates. No estimates. Minimum 5 Quarters needed for worksheet.
Enrollment Projections for the Time Period - P1 = 7/1/2007 through 6/30/2008 P2 = 7/1/2008 through 6/30/2009 *Projections start on a calendar quarter and include data for the entire requested waiver period

| Medicaid Eligibility Group (MEG) | Retrospective Year 1 (R1) ends 6/30/2006 | Retrospective Year 2 (R2) ends 12/31/2006 | Projected Quarter 1 begins 7/1/2007 | Projected Quarter 2 begins 10/1/2007 | Projected Quarter 3 begins 1/1/2008 | Projected Quarter 4 begins 4/1/2008 | Projected Year 1 (P1) | Projected Quarter 5 begins 7/1/2008 | Projected Quarter 6 begins 10/1/2008 | Projected Quarter 7 begins 1/1/2009 | Projected Quarter 8 begins 4/1/2009 | Projected Year 2 (P2) | Total Projected (I+N) |
|---|---|--|--|---|--|--|--------------------------|--|---|--|--|--------------------------|--------------------------|
| TANF | 9,230,780 | 4,681,995 | 2,383,854 | 2,415,810 | 2,437,876 | 2,460,274 | 9,707,817 | 2,483,000 | 2,506,062 | 2,529,465 | 2,553,217 | 10,071,744 | 19,779,561 |
| MCHIP | 190,368 | 96,550 | 62,849 | 59,333 | 53,621 | 54,315 | 214,318 | 54,817 | 55,320 | 55,843 | 56,387 | 222,353 | 436,671 |
| Aged, Blind, and Disabled | 1,542,634 | 770,945 | 368,076 | 368,999 | 369,485 | 369,970 | 1,557,130 | 390,457 | 390,944 | 391,432 | 391,920 | 1,564,753 | 3,121,883 |
| | | | | | | | 0 | | | | | 0 | 0 |
| Total Member Months | 10,963,782 | 5,549,090 | 2,835,379 | 2,858,142 | 2,881,185 | 2,904,559 | 11,479,265 | 2,928,274 | 2,952,332 | 2,976,740 | 3,001,504 | 11,858,850 | 23,338,115 |
| Quarterly % Increase | | | | 0.80% | 0.81% | 0.81% | | 0.82% | 0.82% | 0.83% | 0.83% | | |
| Annualized % Increase R1 to R2 to P1 to P2 | | 1.6% | | | | | 3.4% | | | | | 3.3% | |

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 | 183.00 |
| Gap (end of R2 to P1) | 182.00 |
| P1 | 365.00 |
| P2 | 364.00 |
| TOTAL R2 to P2 | 1094 |
| (Days-365) | 729 |
| TOTAL R2 to P1 | 730 |
| (Days-364) | 365 |

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.

Appendix D2.S Services in Waiver Cost

Row # /
Column
Letter

B C D E F G H I J K

Services in Actual Waiver Cost (Comprehensive and Expedited)

State Michigan

Renewal Waiver

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

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

| State Plan Services | State Plan Approved Services | 1915(b)(3) Services | MCO Capitated Reimbursement | FFS services Impacted by MCO | PCCM Fee-for-Service Reimbursement | PIHP Capitated Reimbursement | PIHP Fee-for-Service Reimbursement | PAIP Capitated Reimbursement | PAIP Fee-for-Service Reimbursement |
|--|------------------------------|---------------------|-----------------------------|------------------------------|------------------------------------|------------------------------|------------------------------------|------------------------------|------------------------------------|
| Inpatient Hospital (excludes psych) | X | | X | | | | | | |
| IHS Inpatient | | | | | | | | | |
| Mental Health Facility | X | | | | | | | | |
| Skilled Nursing Home | X | | | | | | | | |
| Restorative and Rehabilitative (45 day limit for MCOs) | X | | X | | | | | | |
| ICF-MR Public | X | | | | | | | | |
| ICF-MR Private | | | | | | | | | |
| ICF-Other | | | | | | | | | |
| Physician Services (includes 20 day outpatient psych for MCOs) | X | | X | | | | | | |
| Outpatient Hospital (excludes psych) | X | | X | | | | | | |
| IHS Outpatient | | | | | | | | | |
| Prescribed Drugs | X | | X | | | | | | |
| Excludes antipsychotics and HIV/AIDS drugs | | | | X | | | | | |
| Dental Services | X | | | | | | | | |
| Under Age 21 | X | | | | | | | | |
| Other Practitioners (includes psych) | X | | X | | | | | | |
| Certified or Pediatric Nurse Practitioners | X | | X | | | | | | |
| Certified Nurse Anesthetists | X | | X | | | | | | |
| Oral Surgeons (type 10 dental/medical services) | X | | X | | | | | | |
| Nurse Midwives | X | | X | | | | | | |
| Podiatrists | X | | X | | | | | | |
| Chiropractors | X | | X | | | | | | |
| Optometrists | X | | X | | | | | | |
| Clinic Services | X | | X | | | | | | |
| Lab or Radiology (includes psych) | X | | X | | | | | | |
| Home Health Services | X | | X | | | | | | |
| Intermittent or Part-time Nursing Services | X | | X | | | | | | |
| Oxygen, DME and Medical Supplies | X | | X | | | | | | |
| Prosthetics and Orthotics | X | | X | | | | | | |
| Vision Services and Eyeglasses | X | | X | | | | | | |
| Hearing Aids | X | | X | | | | | | |
| Speech and Hearing Services | X | | X | | | | | | |
| Sterilizations | X | | X | | | | | | |
| EPSDT Screening | X | | X | | | | | | |

Row # /
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Administration in Actual Waiver Cost (Comprehensive and Expedited)
State: Michigan
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 | 354,830 | 277,415 |
| B. | COST OF PRIVATE SECTOR CONTRACTORS | | 75% FFP | | |
| 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 | | 75% FFP | | |
| 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 REVIEW | | 75% FFP | | |
| 18. | ENROLLMENT BROKERS | | 50% FFP | 8,321,601 | 4,160,801 |
| 19. | OTHER FINANCIAL PARTICIPATION | | 50% FFP | | |
| | DCH Staff Waiver Administration, per Cost Allocation Plan | | 50% FFP | 7,533,430 | 3,766,715 |
| | HEDIS Contract (Quality Assurance) | | 50% FFP | 556,709 | 278,354 |
| | PBM | | 50% FFP | 1,458,173 | 729,086 |
| | Actuarial Services | | 50% FFP | 184,150 | 92,075 |
| 20 | Total | | | \$ 18,608,893 | \$ 9,304,448 |

*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
See attached Addendum to Appendix D.2.A.

Row # /
Column
Letter
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B C D E F G H I J

Actual Waiver Cost Renewal Comprehensive Version
State: Michigan

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| Medicaid Eligibility Group (MEG) | R1 Member Months | Retrospective Year 1 (R1) Aggregate Costs | | | | | | | Total Actual Waiver Costs (F+G+H+I) |
|--|------------------------|---|--------------------------|--------------------------------------|---|---|-------------------------|-------------------------|---|
| | | MCO/PIHP Capitated Costs (Including incentives and 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, provide documentation) | 1915(b)(3) service costs (provide documentation) | Administration Costs | | |
| TANF | 9,230,780 | \$ 987,315,610 | \$ 182,808,994 | \$ 1,150,324,604 | \$ 1,728,607 | \$ - | \$ 15,667,458 | \$ 1,167,718,068 | |
| MCHIP | 190,368 | \$ 20,364,773 | \$ 3,357,484 | \$ 23,722,257 | \$ 35,594 | \$ - | \$ 323,113 | \$ 24,080,965 | |
| Aged, Blind, and Disabled | 1,542,634 | \$ 958,608,673 | \$ 73,983,810 | \$ 1,032,570,283 | \$ 1,678,650 | \$ - | \$ 2,618,322 | \$ 1,036,867,456 | |
| Total | 10,963,782 | \$ 1,966,487,055 | \$ 240,130,089 | \$ 2,206,617,144 | \$ 3,440,451 | \$ - | \$ 18,808,893 | \$ 2,228,666,488 | |
| R1 Overall PMPM Casemix for R1 (R1 MMs) | | | | | | | | | |

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| Medicaid Eligibility Group (MEG) | R2 Member Months | Retrospective Year 2 (R2) Aggregate Costs | | | | | | | Total Actual Waiver Costs (F+G+H+I) |
|--|------------------------|---|--------------------------|--------------------------------------|---|---|---|-------------------------|---|
| | | MCO/PIHP Capitated Costs (Including incentives and 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, provide documentation) | 1915(b)(3) service costs (provide documentation) | Administration Costs (Attach list using CMS 64.10 Waiver schedule categories) | | |
| TANF | 4,681,595 | \$ 611,084,433 | \$ 85,993,873 | \$ 577,088,408 | \$ 767,793 | \$ - | \$ 7,849,873 | \$ 585,706,074 | |
| MCHIP | 96,550 | \$ 10,539,908 | \$ 1,360,943 | \$ 11,900,849 | \$ 15,834 | \$ - | \$ 161,890 | \$ 12,078,572 | |
| Aged, Blind, and Disabled | 770,945 | \$ 486,719,332 | \$ 28,988,389 | \$ 515,705,721 | \$ 731,176 | \$ - | \$ 1,292,683 | \$ 517,729,581 | |
| Total | 5,549,090 | \$ 1,098,353,671 | \$ 96,341,307 | \$ 1,104,694,978 | \$ 1,514,803 | \$ - | \$ 9,304,446 | \$ 1,115,514,227 | |
| R2 Overall PMPM Casemix for R2 (R2 MMs) | | | | | | | | | |

Modify Line items as necessary to fit the MEGs of the program.
 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 costs in Schedule D from the MBES.
 If the State has 1915(b)(3) or FFS incentives, use State ad hoc reports to calculate amounts 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 Waiver.
 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 Waiver.
 Completion of this Appendix is required for Comprehensive Waivers.

Row # /
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Actual Waiver Cost Renewal Comprehensive Version
State: Michigan

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| 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) |
| TANF | 9,230,780 | \$ 124.62 | \$ 0.19 | \$ - | \$ 1.70 | \$ 126.50 |
| MCHIP | 190,368 | \$ 124.61 | \$ 0.19 | \$ - | \$ 1.70 | \$ 126.50 |
| Aged, Blind, and Disabled | 1,542,634 | \$ 669.36 | \$ 1.09 | \$ - | \$ 1.70 | \$ 672.14 |
| Total | 10,963,782 | | | | | |
| R1 Overall PMPM Casemix for R1 (R1 MMs) | | \$ 201.26 | \$ 0.31 | \$ - | \$ 1.70 | \$ 203.28 |

| 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) |
| TANF | 4,681,595 | \$ 123.27 | \$ 0.16 | \$ - | \$ 1.68 | \$ 125.11 |
| MCHIP | 96,550 | \$ 123.26 | \$ 0.16 | \$ - | \$ 1.68 | \$ 125.10 |
| Aged, Blind, and Disabled | 770,945 | \$ 668.93 | \$ 0.95 | \$ - | \$ 1.68 | \$ 671.55 |
| Total | 5,549,090 | | | | | |
| R2 Overall PMPM Casemix for R2 (R2 MMs) | | \$ 199.08 | \$ 0.27 | \$ - | \$ 1.68 | \$ 201.03 |

Modify Line items as necessary to fit the MEGs of the program.
 State Completion Sections: For a State without FFS incentives or 1915(b)(3), enter 1
 If the State has 1915(b)(3) or FFS incentives, use State ad hoc reports to calculate.
 For these comprehensive states, the total from Columns D, E, G, and H should equal
 Note: The States completing the Expedited Test will only attach the most recent waiver
 Completion of this Appendix is not necessary for expedited waivers.
 Note: The States completing the Comprehensive Test will attach the most recent waiver
 Completion of this Appendix is required for Comprehensive Waivers.

Row # /
Column
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Adjustments and Services in Waiver Cost Projection (Comprehensive and Expedited)

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State: Michigan

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Prospective Years 1 and 2 (P1 and P2)

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Renewal Waiver

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*** If a change please note**

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| Adjustments to the Waiver Cost Projection | Adjustments Made | Location of Adjustment |
|--|------------------|--|
| State Plan Trend | X | Tab D5, Col J, Rows 13 - 15 and 30 - 32 |
| State Plan Programmatic/policy/pricing changes | X | Tab D5, Columns L, Rows 13 - 15 |
| Administrative Cost Adjustment | X | Tab D5, Col Y, Rows 13 - 15 and 30 - 32 |
| 1915(b)(3) service Trend | | |
| Incentives (not in cap payment) Adjustments | X | Tab D5, Column Q, Rows 13 - 15 and 30 - 32 |
| Other | | |

15

State Completion Sections

Row # / Column Letter
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Waiver Cost Projection Renewal Waiver Comprehensive Version
 State: Michigan
 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 | | | | | Prospective Year 1 (P1) Projection for State Plan Services** | | | | | | | | |
|---|---|--------------------------------------|------------------|---------------------------|-----------------------|----------------------------|--|---|---|--|---|--------------------------|--------------------------------------|---|--|
| | | State Plan Service Costs* | Incentive Costs* | 1915(b)(3) Service Costs* | Administration Costs* | Total Actual Waiver Costs* | R2 PMPM State Plan Service Costs* (Same as D13-D18) | State Plan Inflation Adjustment (Annual Year 1) (Preprint Explains) | PMPM Effect of Inflation Adjustment (I+J) | Program Adjustment GME and HRA (Preprint Explains) | PMPM Effect of Program Adjustment ((I+K)xL) | Prescription Drug Rebate | PMPM Effect of Drug Rebate ((I+K)xL) | Aggregate PMPM Effect of State Plan Service Adj. (K+M+AD) | Total P1 PMPM State Plan Service Cost Projection (I+N) |
| TANF | 4,681,595 | \$ 123.27 | \$ 0.16 | \$ - | \$ 1.68 | \$ 125.11 | \$ 123.27 | 10.0% | \$ 13.49 | -15.8% | \$ 21.54 | 0.0% | \$ - | \$ 35.03 | \$ 158.30 |
| MCHIP | 96,550 | \$ 123.26 | \$ 0.16 | \$ - | \$ 1.68 | \$ 125.10 | \$ 123.26 | 10.0% | \$ 13.49 | -15.8% | \$ 21.54 | 0.0% | \$ - | \$ 35.03 | \$ 158.29 |
| Aged, Blind, and Disabled | 770,945 | \$ 668.93 | \$ 0.95 | \$ - | \$ 1.68 | \$ 671.55 | \$ 668.93 | 7.7% | \$ 51.60 | -19.0% | \$ 137.18 | 0.0% | \$ - | \$ 188.78 | \$ 857.70 |
| Total | 5,549,090 | | | | | | | | | | | | | | |
| P1 PMPM Casemix for R2 (R2 MM's) | | \$ 199.08 | \$ 0.27 | \$ - | \$ 1.68 | \$ 201.03 | \$ 199.08 | 9.44% | \$ 18.79 | 17.3% | \$ 37.61 | 0.0% | \$ - | \$ 56.38 | \$ 255.47 |

* 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 64-21LWAV 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 | | | | | Prospective Year 2 (P2) Projection for State Plan Services** | | | | | | | | |
|---|---|--|---|--|--|---|--|---|---|---|---|--------------------------|--------------------------------------|---|--|
| | | 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 Costs (same as W13-W18) | P1 PMPM Administration Service Costs (same as AA13-AA18) | P1 PMPM Total Actual Waiver Costs (same as AB13-AB18) | 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 (I+J) | Program Adjustment [Enter Description Here] (Preprint Explains) | PMPM Effect of Program Adjustment ((I+K)xL) | Prescription Drug Rebate | PMPM Effect of Drug Rebate ((I+K)xL) | Aggregate PMPM Effect of State Plan Service Adj. (K+M+AD) | Total P2 PMPM State Plan Service Cost Projection (I+N) |
| TANF | 4,681,595 | \$ 158.30 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.22 | \$ 158.30 | 6.4% | \$ 10.08 | 0.0% | \$ - | 0.0% | \$ - | \$ 10.08 | \$ 168.38 |
| MCHIP | 96,550 | \$ 158.29 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.21 | \$ 158.29 | 6.4% | \$ 10.08 | 0.0% | \$ - | 0.0% | \$ - | \$ 10.08 | \$ 168.37 |
| Aged, Blind, and Disabled | 770,945 | \$ 857.70 | \$ 0.79 | \$ - | \$ 1.78 | \$ 860.28 | \$ 857.70 | 6.3% | \$ 54.43 | 0.0% | \$ - | 0.0% | \$ - | \$ 54.43 | \$ 912.13 |
| Total | 5,549,090 | | | | | | | | | | | | | | |
| P2 PMPM Casemix for R2 (R2 MM's) | | \$ 255.47 | \$ 0.23 | \$ - | \$ 1.78 | \$ 257.48 | \$ 255.47 | 6.36% | \$ 16.24 | 0.0% | \$ - | 0.0% | \$ - | \$ 16.24 | \$ 271.71 |

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

Row # -
Column
Letter

B P Q R S T U V W X Y Z AA AB

Actual Waiver Cost Conversion Renewal Comprehensive Version

State Michigan

Note: Complete this Appendix for all Prospective Years
Waiver Cost Projection

| 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 (KxY) | Total P1 PMPM Administration Cost Projection (K+Z) | |
| TANF | \$ 0.16 | -15.2% | \$ (0.02) | \$ 0.14 | \$ - | 0.0% | \$ - | \$ - | \$ 1.68 | 0.2% | \$ 0.10 | \$ 1.78 | \$ 160.22 |
| MCHIP | \$ 0.16 | -15.2% | \$ (0.02) | \$ 0.14 | \$ - | 0.0% | \$ - | \$ - | \$ 1.68 | 0.2% | \$ 0.10 | \$ 1.78 | \$ 160.21 |
| Aged, Blind, and Disabled | \$ 0.95 | -16.5% | \$ (0.16) | \$ 0.79 | \$ - | 0.0% | \$ - | \$ - | \$ 1.68 | 0.2% | \$ 0.10 | \$ 1.78 | \$ 860.28 |
| Total | | | | | | | | | | | | | |
| P1 PMPM Casemix for R2 (R2 MMa) | \$ 0.27 | -15.83% | \$ (0.04) | \$ 0.23 | \$ - | 0.00% | \$ - | \$ - | \$ 1.68 | 0.17% | \$ 0.10 | \$ 1.78 | \$ 267.48 |

| 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 (KxY) | Total P2 PMPM Administration Cost Projection (K+Z) | |
| TANF | \$ 0.14 | 6.2% | \$ 0.01 | \$ 0.15 | \$ - | 0.0% | \$ - | \$ - | \$ 1.78 | 0.2% | \$ 0.11 | \$ 1.89 | \$ 170.42 |
| MCHIP | \$ 0.14 | 6.2% | \$ 0.01 | \$ 0.15 | \$ - | 0.0% | \$ - | \$ - | \$ 1.78 | 0.2% | \$ 0.11 | \$ 1.89 | \$ 170.41 |
| Aged, Blind, and Disabled | \$ 0.79 | 6.2% | \$ 0.05 | \$ 0.84 | \$ - | 0.0% | \$ - | \$ - | \$ 1.78 | 0.2% | \$ 0.11 | \$ 1.89 | \$ 914.86 |
| Total | | | | | | | | | | | | | |
| P2 PMPM Casemix for R2 (R2 MMa) | \$ 0.23 | 6.22% | \$ 0.01 | \$ 0.24 | \$ - | 0.00% | \$ - | \$ - | \$ 1.78 | 0.17% | \$ 0.11 | \$ 1.89 | \$ 273.84 |

Modify Line Items as necessary to fit the MEGs of the program

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
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 | |
| TANF | 9,707,817 | \$ 158.30 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.22 | \$ 158.44 |
| MCHIP | 214,318 | \$ 158.25 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.21 | \$ 158.43 |
| Aged, Blind, and Disabled | 1,557,130 | \$ 657.70 | \$ 0.79 | \$ - | \$ 1.78 | \$ 860.28 | \$ 858.50 |
| Total | 11,479,265 | | | | | | |
| P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | | \$ 253.17 | \$ 0.23 | \$ - | \$ 1.78 | \$ 255.18 | |

| 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 | |
| TANF | 2,393,854 | \$ 379,280,133.74 | \$ 4,261,556.28 | 2,415,810 | \$ 382,758,823.18 | \$ 4,300,642.51 | 2,437,879 | \$ 386,255,416.23 | \$ 4,339,929.90 | 2,460,274 | \$ 389,803,680.44 | \$ 4,379,797.64 | \$ 1,533,379,959.91 |
| MCHIP | 52,849 | \$ 8,372,945.87 | \$ 94,082.17 | 53,333 | \$ 8,449,626.71 | \$ 94,943.79 | 53,821 | \$ 8,526,941.28 | \$ 95,812.54 | 54,315 | \$ 8,605,206.44 | \$ 96,691.96 | \$ 34,336,250.76 |
| Aged, Blind, and Disabled | 389,676 | \$ 333,676,762.36 | \$ 691,923.94 | 388,999 | \$ 333,054,056.55 | \$ 692,496.84 | 389,465 | \$ 334,371,285.57 | \$ 693,364.03 | 389,970 | \$ 334,787,656.09 | \$ 694,227.43 | \$ 1,339,561,774.71 |
| Total | 2,835,379 | \$ 721,329,841.98 | \$ 5,047,562.29 | 2,858,142 | \$ 725,162,506.44 | \$ 5,088,085.15 | 2,881,185 | \$ 729,153,643.08 | \$ 5,129,186.46 | 2,904,559 | \$ 733,196,522.97 | \$ 5,170,717.03 | \$ 2,929,277,965.38 |

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 | |
| TANF | 10,071,744 | \$ 168.38 | \$ 0.15 | \$ - | \$ 1.89 | \$ 170.42 | \$ 168.53 |
| MCHIP | 222,353 | \$ 168.37 | \$ 0.15 | \$ - | \$ 1.89 | \$ 170.41 | \$ 168.52 |
| Aged, Blind, and Disabled | 1,564,753 | \$ 912.13 | \$ 0.84 | \$ - | \$ 1.89 | \$ 914.86 | \$ 912.97 |
| Total | 11,858,850 | | | | | | |
| P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | | \$ 266.51 | \$ 0.24 | \$ - | \$ 1.89 | \$ 268.64 | |

| 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 | |
| TANF | 2,483,000 | \$ 418,448,653.71 | \$ 4,692,984.34 | 2,506,062 | \$ 422,335,187.28 | \$ 4,736,572.59 | 2,529,465 | \$ 426,279,188.02 | \$ 4,780,805.33 | 2,553,217 | \$ 430,282,004.14 | \$ 4,825,697.71 | \$ 1,716,381,093.11 |
| MCHIP | 54,817 | \$ 9,237,613.62 | \$ 103,606.65 | 55,326 | \$ 9,323,388.93 | \$ 104,568.69 | 55,843 | \$ 9,410,512.38 | \$ 105,545.84 | 56,367 | \$ 9,498,816.45 | \$ 106,536.23 | \$ 37,890,587.78 |
| Aged, Blind, and Disabled | 390,457 | \$ 356,475,801.38 | \$ 737,581.71 | 390,944 | \$ 356,920,418.11 | \$ 738,902.16 | 391,432 | \$ 357,365,947.81 | \$ 739,824.51 | 391,920 | \$ 357,811,477.52 | \$ 740,746.85 | \$ 1,431,531,100.05 |
| Total | 2,928,274 | \$ 784,162,668.70 | \$ 5,534,572.71 | 2,952,332 | \$ 788,578,994.32 | \$ 5,580,043.44 | 2,976,740 | \$ 793,055,648.21 | \$ 5,626,175.68 | 3,001,504 | \$ 797,592,297.11 | \$ 5,672,980.78 | \$ 3,185,802,780.95 |

P Q R S T U

Quarterly CMS Targets for RO CMS-64 Review Renewal
 State: Michigan
 Projection for Upcoming Waiver Period
 Projections for RO CMS-64 Certification - Aggregate Cost

Projected Year 1 7/1/2007 through 6/30/2008

| Waiver Form | Medicaid Eligibility Group (MEG) | Q1 Quarterly Projected Costs Quarter Ending (QE) 9/30/2007 | Q2 Quarterly Projected Costs Quarter Ending (QE) 12/31/2007 | Q3 Quarterly Projected Costs Quarter Ending (QE) 3/31/2008 | Q4 Quarterly Projected Costs Quarter Ending (QE) 6/30/2008 |
|--------------------|----------------------------------|--|---|--|--|
| 64.21U Waiver Form | TANF | \$ 379,280,133.74 | \$ 382,758,823.18 | \$ 386,255,416.23 | \$ 389,803,660.44 |
| 64.21U Waiver Form | MCHIP | \$ 8,372,945.87 | \$ 8,449,626.71 | \$ 8,526,941.28 | \$ 8,605,206.44 |
| 64.9 Waiver Form | Aged, Blind, and Disabled | \$ 333,676,762.36 | \$ 333,954,056.55 | \$ 334,371,285.57 | \$ 334,787,656.09 |
| 64.10 Waiver Form | | \$ 5,047,562.29 | \$ 5,088,085.15 | \$ 5,129,106.46 | \$ 5,170,717.03 |

Projected Year 1 7/1/2008 through 6/30/2009

| Waiver Form | Medicaid Eligibility Group (MEG) | Q5 Quarterly Projected Costs Quarter Ending (QE) 9/30/2008 | Q6 Quarterly Projected Costs Quarter Ending (QE) 12/31/2008 | Q7 Quarterly Projected Costs Quarter Ending (QE) 3/31/2009 | Q8 Quarterly Projected Costs Quarter Ending (QE) 6/30/2009 |
|--------------------|----------------------------------|--|---|--|--|
| 64.21U Waiver Form | TANF | \$ 418,448,653.71 | \$ 422,335,187.28 | \$ 426,279,188.02 | \$ 430,282,004.14 |
| 64.21U Waiver Form | MCHIP | \$ 9,237,613.62 | \$ 9,323,388.93 | \$ 9,410,512.38 | \$ 9,498,815.45 |
| 64.9 Waiver Form | Aged, Blind, and Disabled | \$ 356,475,801.38 | \$ 356,920,418.11 | \$ 357,365,947.81 | \$ 357,811,477.52 |
| 64.10 Waiver Form | | \$ 5,534,572.71 | \$ 5,580,043.44 | \$ 5,626,175.68 | \$ 5,672,980.78 |

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

Quarterly CMS Targets for RO Cost-Effectiveness Monitoring
 State: Michigan
 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 | TANF | \$ | 158.44 |
| 64.21U Waiver Form | MCHIP | \$ | 158.43 |
| 64.9 Waiver Form | Aged, Blind, and Disabled | \$ | 858.50 |
| 64.10 Waiver Form | All MEGS | \$ | 1.78 |

Projected Year 1

| Waiver Form | Medicaid Eligibility Group (MEG) | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | |
|--------------------|----------------------------------|--|-------------------|-------------------|--|-------------------|-------------------|--|-------------------|-------------------|--|-------------------|-------------------|
| | | Q1 Quarterly Actual Costs | | | Q2 Quarterly Actual Costs | | | Q3 Quarterly Actual Costs | | | Q4 Quarterly Actual Costs | | |
| | | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs |
| 64.21U Waiver Form | TANF | 09/30/07 | Waiver Form Costs | | 12/31/07 | Waiver Form Costs | | 03/31/08 | Waiver Form Costs | | 06/30/08 | Waiver Form Costs | |
| 64.21U Waiver Form | MCHIP | | | | | | | | | | | | |
| 64.9 Waiver Form | Aged, Blind, and Disabled | | | | | | | | | | | | |
| 64.10 Waiver Form | All MEGS | | | | | | | | | | | | |

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 | TANF | \$ | 168.53 |
| 64.21U Waiver Form | MCHIP | \$ | 168.52 |
| 64.9 Waiver Form | Aged, Blind, and Disabled | \$ | 912.97 |
| 0 | 0 | | |
| 64.10 Waiver Form | All MEGS | \$ | 1.89 |

Projected Year 1

| Waiver Form | Medicaid Eligibility Group (MEG) | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | | RO Completion Section - For ongoing monitoring | | |
|--------------------|----------------------------------|--|-------------------|-------------------|--|-------------------|-------------------|--|-------------------|-------------------|--|-------------------|-------------------|
| | | Q5 Quarterly Actual Costs | | | Q6 Quarterly Actual Costs | | | Q7 Quarterly Actual Costs | | | Q8 Quarterly Actual Costs | | |
| | | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs | Member Months Actuals for QE | Actual Aggregate | Actual PMPM Costs |
| 64.21U Waiver Form | TANF | 09/30/08 | Waiver Form Costs | | 12/31/08 | Waiver Form Costs | | 03/31/09 | Waiver Form Costs | | 06/30/09 | Waiver Form Costs | |
| 64.21U Waiver Form | MCHIP | | | | | | | | | | | | |
| 64.9 Waiver Form | Aged, Blind, and Disabled | | | | | | | | | | | | |
| 64.10 Waiver Form | All MEGS | | | | | | | | | | | | |

File
Column
Enter

Cost Effectiveness Summary Sheet Renewal Waiver
State Michigan

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 Per Member Per Month (PMPM) Costs | | | | Total Actual Waiver Costs |
|----------------------|--|-------------------|--------------------------------------|-------------------------|----------------------------------|------------------------------|---------------------------|
| | | | R1 PMPM State Plan Service Costs | R1 PMPM Incentive Costs | R1 PMPM 1915(b)(3) Service Costs | R1 PMPM Administration Costs | |
| | TANF | 5,230,780 | \$ 124.82 | \$ 0.19 | \$ - | \$ 1.70 | \$ 109.90 |
| | MCHIP | 190,348 | \$ 124.61 | \$ 0.19 | \$ - | \$ 1.70 | \$ 126.50 |
| | Aged, Blind, and Disabled | 1,642,634 | \$ 969.36 | \$ 1.09 | \$ - | \$ 1.70 | \$ 672.14 |
| | Total | 15,963,742 | | | | | 203.28 |
| | R1 Overall PMPM Casemix for R1 (R1 MMs) | | \$ 203.28 | \$ 0.31 | \$ - | \$ 1.70 | \$ 203.28 |
| | Total R1 Expenditures | | | | | | \$ 2,218,566,488 |

| P1 Per Member Per Month (PMPM) Costs from the prior waiver submission | | | | | |
|---|-------------------------|----------------------------------|------------------------------|-----------------------------------|-------------------------|
| 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 | |
| \$ 138.31 | \$ 0.31 | \$ - | \$ 1.68 | \$ 140.27 | |
| \$ 129.21 | \$ 0.28 | \$ - | \$ 1.69 | \$ 131.14 | |
| \$ 706.06 | \$ 1.83 | \$ - | \$ 1.68 | \$ 708.35 | |
| \$ 217.43 | \$ 0.43 | \$ - | \$ 1.65 | \$ 219.04 | |
| Total Previous P1 Projection using R1 member months | | | | | \$ 2,412,502,538 |

| Retrospective Period | Medicaid Eligibility Group (MEG) | R2 Member Months | R2 Per Member Per Month (PMPM) Costs (Totals weighted on Retrospective Year 2 Member Months) | | | | Overall R1 to R2 Change (annual) | |
|----------------------|---|------------------|--|-------------------------|----------------------------------|------------------------------|----------------------------------|-------------------------|
| | | | R2 PMPM State Plan Service Costs | R2 PMPM Incentive Costs | R2 PMPM 1915(b)(3) Service Costs | R2 PMPM Administration Costs | | |
| | TANF | 4,681,395 | \$ 123.27 | \$ 0.16 | \$ - | \$ 1.62 | \$ 125.11 | -1.5% |
| | MCHIP | 96,550 | \$ 123.26 | \$ 0.16 | \$ - | \$ 1.62 | \$ 125.10 | -1.5% |
| | Aged, Blind, and Disabled | 770,545 | \$ 968.53 | \$ 0.95 | \$ - | \$ 1.62 | \$ 671.55 | -0.1% |
| | Total | 5,549,090 | | | | | | -0.2% |
| | R2 Weighted Average PMPM Casemix for R1 (R1 MMs) | | \$ 200.04 | \$ 0.27 | \$ - | \$ 1.63 | \$ 201.99 | -0.2% |
| | R2 Overall PMPM Casemix for R2 (R2 MMs) | | \$ 199.08 | \$ 0.27 | \$ - | \$ 1.63 | \$ 201.03 | -1.5% |
| | Total R2 Expenditures | | | | | | | \$ 1,115,514,227 |

| P2 Per Member Per Month (PMPM) Costs from the prior waiver submission | | | | | |
|---|-------------------------|----------------------------------|------------------------------|-----------------------------------|-------------------------|
| 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 | |
| \$ 162.87 | \$ 0.32 | \$ - | \$ 1.70 | \$ 165.03 | |
| \$ 150.25 | \$ 0.29 | \$ - | \$ 1.74 | \$ 154.26 | |
| \$ 894.89 | \$ 1.70 | \$ - | \$ 1.72 | \$ 898.47 | |
| \$ 258.91 | \$ 0.51 | \$ - | \$ 1.74 | \$ 261.16 | |
| Total Previous P2 Projection using R2 member months | | | | | \$ 1,449,291,411 |

| | | | | | | | | |
|---|--|--|--|--|--|--|--|-------------------------|
| Total Previous Waiver Period Expenditures (Casemix for R1 and R2) | | | | | | | | \$ 3,344,160,716 |
| Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period | | | | | | | | \$ 317,815,232 |

| | | | | | | | | |
|--|--|--|--|--|--|--|--|-------------------------|
| | | | | | | | | \$ 3,861,795,947 |
|--|--|--|--|--|--|--|--|-------------------------|

| Prospective Period | Medicaid Eligibility Group (MEG) | Projected Year 1 Member Months (P1) | P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months) | | | | | Overall R2 to P1 Change (annual) |
|--------------------|---|-------------------------------------|---|-----------------------------------|--|--|--------------------------------|----------------------------------|
| | | | 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 | |
| | TANF | 8,707,817 | \$ 152.30 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.22 | 21.9% |
| | MCHIP | 214,318 | \$ 152.25 | \$ 0.14 | \$ - | \$ 1.78 | \$ 160.21 | 21.9% |
| | Aged, Blind, and Disabled | 1,357,130 | \$ 657.79 | \$ 0.79 | \$ - | \$ 1.78 | \$ 660.26 | 21.9% |
| | Total | 11,479,265 | | | | | | |
| | P1 Weighted Average PMPM Casemix for R2 (R2 MMs) | | \$ 255.47 | \$ 0.23 | \$ - | \$ 1.78 | \$ 257.48 | 21.9% |
| | P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | | \$ 253.17 | \$ 0.23 | \$ - | \$ 1.78 | \$ 255.18 | 21.0% |
| | Total Projected Waiver Expenditures P1(P1 MMs) | | | | | | | \$ 2,929,277,585 |

| Prospective Period | Medicaid Eligibility Group (MEG) | Projected Year 2 Member Months (P2) | P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months) | | | | | Overall P1 to P2 Change (annual) |
|--------------------|---|-------------------------------------|---|-----------------------------------|--|--|--------------------------------|----------------------------------|
| | | | 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 | |
| | TANF | 10,071,744 | \$ 169.38 | \$ 0.15 | \$ - | \$ 1.89 | \$ 170.42 | 6.4% |
| | MCHIP | 222,350 | \$ 169.37 | \$ 0.15 | \$ - | \$ 1.89 | \$ 170.41 | 6.4% |
| | Aged, Blind, and Disabled | 1,564,753 | \$ 912.13 | \$ 0.84 | \$ - | \$ 1.89 | \$ 914.96 | 6.3% |
| | Total | 11,858,850 | | | | | | |
| | P2 Weighted Average PMPM Casemix for R1 (R1 MMs) | | \$ 289.27 | \$ 0.24 | \$ - | \$ 1.89 | \$ 271.40 | 6.4% |
| | P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | | \$ 286.51 | \$ 0.24 | \$ - | \$ 1.89 | \$ 268.64 | 5.3% |
| | Total Projected Waiver Expenditures P2 (P2 MMs) | | | | | | | \$ 3,185,802,791 |

| Prospective Period | Medicaid Eligibility Group (MEG) | Projected Year 1 and 2 Member Months (P1+P2) | Overall R1 to P2 Change (daily) | | Overall R1 to P2 Change (annualized) | |
|--------------------|--|--|---------------------------------|------------------|--------------------------------------|-------------------------|
| | | | R1 | P2 | R1 | P2 |
| | TANF | 19,779,561 | 0.04% | 15.1% | 0.04% | 15.1% |
| | MCHIP | 436,671 | 0.04% | 15.1% | 0.04% | 15.1% |
| | Aged, Blind, and Disabled | 3,121,883 | 0.04% | 16.7% | 0.04% | 16.7% |
| | Total | 23,338,115 | | | | |
| | P3 Weighted Average PMPM Casemix for R1 (R1 MMs) | | \$ 203.28 | \$ 271.40 | 0.04% | 15.6% |
| | P3 Weighted Average PMPM Casemix for P2 (P2 MMs) | | \$ 198 | \$ 268.64 | 0.04% | 16.4% |
| | Total Projected Waiver Expenditures P2 + P1 (Casemix for P1 and P2) | | | | | \$ 6,115,080,766 |

Modify data items as necessary to fit the MEGs of the program.
 State Comptroller's Office, PMPMs from prospective approval waiver.
 To modify the formulas as necessary to fit the length of the program, please ensure that Appendix D7 is completed entirely. The formulas will automatically update given the data.