DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

June 21, 2019

Kate Massey
State Medicaid Director
Medical Services Administration
Michigan Department of Health & Human Services
400 South Pine Street
Lansing, MI 48933

Dear Ms. Massey:

The Centers for Medicare & Medicaid Services (CMS) approves the Michigan Department of Health & Human Services' (MDHHS) request to amend the MI Choice home and community-based services waiver authorized under sections 1915(b) and 1915(c) of the Social Security Act. The waiver amendments are assigned control numbers MI-18.R01.M01 and MI.0233.R05.01, respectively, which the state should use in all future correspondence.

The MI Choice waivers were amended to remove Community Transition Services from the waiver benefit effective July 1, 2019. Going forward, the state will provide Community Transition Services under the approved section 1915(i) State Plan benefit. The waivers will continue to serve elderly individuals ages 65 and older, as well as disabled individuals ages 18 and older, who meet a nursing facility level of care.

The section 1915(c) MI Choice waiver amendment estimates the following utilization and cost of waiver services:

	Unduplicated Recipients (Factor C)	**Community Costs (Factor D+D')**	**Institutional Costs (Factor G+G')**	**Total Waiver Costs (Factor C x Factor D)**
Year 1	16856	$25,190	$46,123	$337,181,019
Year 2	17402	$25,389	$47,148	$349,785,247
Year 3	18056	$25,423	$48,196	$361,678,653
Year 4	18854	$25,619	$49,266	$379,333,619
Year 5	19796	$25,895	$50,361	$401,604,223

It is important to note that CMS' approval of the MI Choice waiver amendments solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

We would greatly appreciate ongoing communication with the state to help keep us informed of any changes or updates related to these waivers. If you have any questions related to these approvals, please contact Eowyn Ford at 312-886-1684 or eowyn.ford@cms.hhs.gov .

Sincerely,

Ruth A. Hughes
Deputy Director
Center for Medicaid & CHIP Services
Regional Operations Group

cc: Jacqueline Coleman, MDHHS

Facesheet: 1. Request Information (1 of 2)

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

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
MI Choice	MI Choice	PAHP;	

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

MI Choice Amendment - Removal of Community Transition Services

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**
The amendment modifies (Sect/Part):

Removal of references to Community Transition Services due to services being offered under the new 1915i and no longer through the MI Choice Waiver. The areas being amended are:
Section A
- Part I, F(8) Other
- Tribal Consultation

Section D, Part I services
Other updates to Section D5

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year**
○ **2 years**
○ **3 years**
○ **4 years**
◉ **5 years**

Draft ID:MI.028.01.01
Waiver Number:MI.0018.R01.01

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)
Approved Effective Date of Base Waiver being Amended: 11/13/18
Proposed Effective Date: (mm/dd/yy)

07/01/19

Approved Effective Date: 07/01/19

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Jacqueline Coleman

Phone: (517) 284-1190 **Ext:** ☐ **TTY**

Fax: (517) 241-5112

E-mail:

ColemanJ@michigan.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **MI Choice**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

MDHHS completed a Tribal notification and comment period from February 7, 2019 through March 25, 2019. No comments or questions were received.

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).

MI Choice is a § 1915(c) waiver used to deliver home and community based services to elderly and disabled individuals meeting Michigan's nursing facility level of care who, but for the provision of such services, would require services provide in a nursing facility. The goal is to provide home and community based services and supports to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. The waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Medical Services Administration (MSA), which is the Single State Medicaid Agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations.

MI Choice is a Medicaid managed care program. MI Choice participants receive services from entities classified as Prepaid Ambulatory Health Plans (PAHPs), otherwise referred to as waiver agencies. MDHHS contracts with waiver agencies to carry out its waiver obligations. Each waiver agency must sign a provider agreement with MDHHS assuring that it meets all program requirements.

Waiver agencies may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under subcontract with the waiver agency must meet provider standards described elsewhere in the waiver application. Subcontracts also assure that providers of services receive full reimbursement for services outlined in the waiver application. Providers meeting the requirements outlined in the waiver are permitted to participate.

MI Choice operates concurrently with the §1915(c) waiver MI.0233.R05.00. Participants enrolled in MI Choice may not be enrolled simultaneously in another of Michigan's §1915(c) waivers.

The major changes included in this waiver renewal are:

1) Combining the Non-Emergency Medical Transportation and Non-Medical Transportation services into one transportation service.

2) Changing the interRAI Home Care assessment frequency to 90-days after the initial assessment and then annually thereafter, and having person-centered planning meetings in lieu of the 180-day assessment that has been required in the past.

3) Addition of nursing facilities as providers of the out-of-home Respite in an effort to expand setting possibilities for this service for individuals whose needs cannot be met in other settings.

4) Revision and addition of some performance measures for the Quality Improvement Strategy.

5) Reiterating that communication is an important function of the Supports Coordination service, and frequency of the communication between the Supports Coordinator and participant (or legal representative) must be identified in the person-centered service plan.

6) Addition of a service called Community Health Worker to utilize unlicensed supports brokers to assure participants' needs are met and community resources are located and arranged if needed. This service provider may have more contact with the participant than the Supports Coordinator.

7) Addition of Respiratory Care to the Private Duty Nursing service to serve those individuals who are ventilator dependent. The service will now be titled Private Duty Nursing/Respiratory Care, and Respiratory Therapists will be permitted as service providers.

8) Changed language pertaining to appeals to be compliant with the requirements of the Managed Care Rule.

9) Changed the percentage of providers that must undergo provider monitoring on an annual basis. This percentage used to be 10%, but MDHHS increased it to 20%.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority

provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
-- *Specify Program Instance(s) applicable to this authority*

☒ **MI Choice**

b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
-- *Specify Program Instance(s) applicable to this authority*

☐ **MI Choice**

c. ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
-- *Specify Program Instance(s) applicable to this authority*

☐ **MI Choice**

d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
-- *Specify Program Instance(s) applicable to this authority*

☒ **MI Choice**

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

☐ **MCO**

☐ **PIHP**

☒ **PAHP**

☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

☐ **FFS** Selective Contracting program
Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- *Specify Program Instance(s) applicable to this statute*

☐ **MI Choice**

b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
-- *Specify Program Instance(s) applicable to this statute*

☒ **MI Choice**

c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
-- *Specify Program Instance(s) applicable to this statute*

☒ **MI Choice**

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).

Beneficiaries must enroll into a single PAHP in regions that only have one PAHP available. These regions are: Region 1A, Region 2, Region 5, Region 6, Region 9 and Region 11.

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

☒ **MI Choice**

e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

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

☐ **MI Choice**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

The level of enrollment does not justify multiple PAHPs in those regions that only have one PAHP available.

Due to Section A, Part III, Item 2 not yet being updated to reflect current 42 CFR 438 regulations, and it did not seem appropriate to add an assurance under the waiver comment area within Section A, Part III, Item 2, MDHHS is adding assurance language here. MDHHS complies with/will comply with 42 CFR Part 438 Subpart E as it applies to PAHPs.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

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

- ◉ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

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

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)

- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PIHP**

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

☒ **Procurement for PAHP**

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

MDHHS used a competitive procurement process in the past to select the waiver agencies. The waiver agencies are remaining in place as the PAHPs and MDHHS is not undergoing another competitive procurement process at this time.

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

MDHHS currently contracts with 20 waiver agencies throughout the state to operate and administer the MI Choice waiver. Each waiver agency is responsible for subcontracting with provider agencies to provide MI Choice services to participants who qualify for these services. This 1915(b) waiver runs concurrently with the MI Choice 1915(c) waiver, control number MI.0233.R05.00.

Section A: Program Description

Part I: Program Overview

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

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 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

In the regions with only one PAHP, participants will still have a choice in service providers, including supports coordinators. Participants enrolled with the single PAHP in the service area will be allowed to change supports coordinators upon request. MDHHS will continue to ensure the PAHP has an adequate provider network to assure this choice.

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

Program: " **MI Choice.** *"*

☐ **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

In regions that have two PAHPs, participants choose to enroll with their preferred PAHP.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

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

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

◉ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

Some regions/service areas only include one PAHP, but participants are given a choice of providers under that one PAHP. The other regions include more than one PAHP with choice of service providers.

○ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

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

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*

     ☒ **MI Choice**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☐ **MI Choice**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 14 - Oceana, Muskegon, Ottawa	PAHP - Waiver Agency	Senior Resources
Region 8 - Lake Osceola, Newaygo, Mecosta, Montcalm, Kent, Ionia, Allegan, Mason	PAHP - Waiver Agency	Area Agency on Aging of Western Michigan
Region7-Clare Gladwin Isabella Midland Bay Gratiot Saginaw Tuscola Huron Sanilac	PAHP - Waiver Agency	Region VII Area Agency on Aging
Region 10*	PAHP - Waiver Agency	AAA Northwest Michigan
Region 1B - St. Clair, Macomb, Oakland, Livingston, Washtenaw, Monroe	PAHP - Waiver Agency	MORC Home Care, Inc.
Region 8 - Lake Osceola, Newaygo, Mecosta, Montcalm, Kent, Ionia, Allegan, Mason	PAHP - Waiver Agency	Reliance Community Care Partners
Region 11*	PAHP - Waiver Agency	UPCAP
Region 10*	PAHP - Waiver Agency	Northern Lakes Community Mental Health
Region 4 - Van Buren, Berrien, Cass	PAHP - Waiver Agency	Region IV Area Agency on Aging

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1C - Wayne	PAHP - Waiver Agency	The Information Center
Region 1B - St. Clair, Macomb, Oakland, Livingston, Washtenaw, Monroe	PAHP - Waiver Agency	Area Agency on Aging 1B
Region 3 - Barry, Kalamazoo, Calhoun, St. Joseph, Branch	PAHP - Waiver Agency	Region 3B Area Agency on Aging
Region 6 - Clinton, Eaton, Ingham	PAHP - Waiver Agency	Tri-County Office on Aging
Region 3 - Barry, Kalamazoo, Calhoun, St. Joseph, Branch	PAHP - Waiver Agency	Senior Services, Inc.
Region 14 - Oceana, Muskegon, Ottawa	PAHP - Waiver Agency	Reliance Community Care Partners
Region 5 - Shiawassee, Genesee, Lapeer	PAHP - Waiver Agency	Valley Area Agency on Aging
Region 4 - Van Buren, Berrien, Cass	PAHP - Waiver Agency	Region 3B Area Agency on Aging
Region7-Clare Gladwin Isabella Midland Bay Gratiot Saginaw Tuscola Huron Sanilac	PAHP - Waiver Agency	A&D Home Health Care, Inc.
Region 1C - Wayne	PAHP - Waiver Agency	The Senior Alliance
Region 1A - Wayne	PAHP - Waiver Agency	Detroit Area Agency on Aging
Region 9*	PAHP - Waiver Agency	Northeast MI Community Service Agency, Inc.
Region 2 - Jackson, Hillsdale, Lenawee	PAHP - Waiver Agency	Region 2 Area Agency on Aging

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

*Regions 9, 10, and 11 are listed as geographic areas served by this waiver. The following details which counties comprise those Regions:

Region 9 - Cheboygan, Presque Isle, Otsego, Montmorency, Alpena, Crawford, Oscoda, Alcona, Roscommon, Ogemaw, Iosco, Arenac

Region 10 - Emmet, Charlevoix, Leelanau, Antrim, Benzie, Grand Traverse, Kalkaska, Manistee, Wexford, Missaukee

Region 11 - Keweenaw, Ontonagon, Houghton, Baraga, Marquette, Alger, Luce, Chippewa, Gogebic, Iron, Dickinson, Menominee, Delta, Schoolcraft, Mackinac

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

1. Included Populations. The following populations are included in the Waiver Program:

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Other** (Please define):

Included populations are individuals enrolled in the Section 1915(c) MI Choice waiver, control number MI.0233.R05.00. MI Choice is available to persons 18 years of age or older who meet financial and functional eligibility requirements, and have a need for at least one waiver service in addition to Supports Coordination.

Individuals with special health care needs are partially excluded from the MI Choice Waiver because of different age restrictions. Special Health Care Needs is defined as those individuals enrolled in the Title V Children's Special Health Care Services (CSHCS) program. Individuals in this program are generally eligible until Age 21, with the exception of some limited diagnosis that allow eligibility without an age limit. MI Choice services are available only to adults aged 18 or older. CSHCS participants are excluded from the MI Choice Private Duty Nursing service until age 21 because this services is covered through the State Plan through age 20. CSHCS beneficiaries aged 18 or older who otherwise meet eligibility criteria for the MI Choice program may enroll in MI Choice for HCBS. All MI Choice Waiver services provided to individuals also enrolled with CSHCS must be carefully coordinated across programs to meet the individual's needs and avoid duplication of services.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

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

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

☒ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☐ **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.

☒ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

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

Children with special health care needs are those eligible for Michigan's Children's Special Health Care Services program. Individuals eligible are persons under the age of 21 with one or more qualifying medical diagnoses. Persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia are also included. Medical eligibility must be established by physicians in the MDHHS Office of Medical Affairs and is based on the diagnosis, chronicity and severity of the diagnosis(es). These individuals are excluded from the Private Duty Nursing service under the MI Choice Waiver.

☒ **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):

Excluded population - "Participate in HCBS Waiver" checked above refers to participants enrolled in other non-MI Choice 1915(c) waivers. Individuals enrolled in the Managed Specialty Services and Supports Program may also be enrolled in this waiver. The spenddown population is excluded from participating in the MI Choice waiver program.

Individuals may remain enrolled in MI Choice if they temporarily reside in nursing facilities when using the out-of-home Respite service.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

☒ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

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

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for

compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☒ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

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

   ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

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

   ☐ Other (please explain):

☒ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☐ 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.

FQHC Services Category General Comments (optional):

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.

EPSDT Requirements Category General Comments (optional):

MI Choice does not cover EPSDT benefits. Any MI Choice participant who is eligible for EPSDT will receive these benefits through the State Plan.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

☐ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

8. Other.

☒ Other (Please describe)

CMS approved waiver services include: Adult Day Health, Community Health Worker, Respite, Specialized Medical Equipment and Supplies, Fiscal Intermediary, Goods and Services, Chore Services, Community Living Supports, Counseling, Environmental Accessibility Adaptations, Home Delivered Meals, Community Transportation, Personal Emergency Response System, Private Duty Nursing/Respiratory Care, Training, Supports Coordination, and Nursing Services.

The services and provider options being added in this waiver renewal are:
1) Addition of nursing facilities as out-of-home Respite settings,
2) Addition of Respiratory Care within the Private Duty Nursing service and allowing Respiratory Therapists as providers,
3) Addition of a Community Health Worker service, and
4) Combination of Non-Emergency Medical Transportation and Non-Medical Transportation into one Community Transportation service.

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

MDHHS is working towards the implementation of an Electronic Visit Verification (EVV) system. The time frame when the system will be fully functional is unknown at this time.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiarys normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States 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 States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

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

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

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

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☒ The plan is a PIHP/PAHP, and the State has determined that based on the plans 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:

Individuals with special health care needs are partially excluded from the MI Choice Waiver. This is defined as those individuals enrolled in the Title V Children's Special Health Care Services (CSHCS) program. They are excluded from the MI Choice Private Duty Nursing service until age 21. If the individuals require more Community Living Supports than available through the State Plan personal care benefit and Community Mental Health services, they may receive those services through the MI Choice Waiver.

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:

MI Choice Waiver agencies have the ability to view other program enrollment within the CHAMPS MMIS system if the individual is enrolled with them and they know the Medicaid ID.

c. ☒ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

The assessment process would remain the same as any MI Choice Waiver participant, though would require careful coordination with the CSHCS program.

d. ☒ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☒ Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
2. ☒ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

Treatment plans remain the responsibility of CSHCS and MI Choice includes the person-centered service plans, which may differ from the treatment plans. The two programs/entities must collaborate to assure they are not duplicating services.

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 enrollees condition and identified needs.

Please describe:

MI Choice Waiver participants are allowed to see specialists as appropriate for the condition and identified needs indicated in the treatment plan. Medical transportation is available to participants to attend appointments with specialists as necessary. Maintaining the enrollment in CSHCS assures access to specialists and since MI Choice does not cover primary care services, it does not interfere with this access.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees 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 managers files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

As required per the contract between the waiver agency and MDHHS, the waiver agency supports coordinator is responsible for working with the participant to develop a person-centered service plan and coordination of supports and services for all participants served by the waiver agency. Also, as part of the contract, all services inclusive of Supports Coordination and responsibility for development of an individual person-centered service plan are housed within the waiver agency to facilitate care coordination. Through the Administrative Quality Assurance Review and the Clinical Quality Assurance Review, MDHHS monitors that these requirements are met, and assures continuity and coordination of care.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ 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.

☐ 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:
(mm/dd/yy)

☐ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCMs response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to States medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollees PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments

12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   A. ☐ Initial credentialing
   B. ☐ Performance measures, including those obtained through the following (check all that apply):
      - ☐ The utilization management system.
      - ☐ The complaint and appeals system.
      - ☐ Enrollee surveys.
      - ☐ Other.

      Please describe:
4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or

terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☒ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☐ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

   Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the States 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. ☐ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☐ The languages comprise all languages in the service area spoken by approximately [ ] percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ 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:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Generally, Prevalent Language is defined as Specific Non-English Language that is spoken as the primary language by more than 5% of the population of individual applying for or enrolled in the MI Choice Waiver. Enrollee materials are translated into all Prevalent Languages.

If the State does not translate or require the translation of marketing materials, please explain:

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

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines significant.:

b. ☐ The languages spoken by approximately _____ percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☒ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The waiver agencies assure accommodation for people with Limited English Proficiency (LEP) and other linguistic needs, as well as for individuals with hearing impairments and alternative needs for communication. The MDHHS site review process assures compliance with this requirement.

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

Please describe:

The waiver agencies have a participant handbook created by MDHHS that explains the program, rights and responsibilities, etc. This will go to everyone assessed and is available to anyone asking about the program.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State

☒ Contractor

Please specify:

Waiver agencies speak with potential enrollees and give them information, if the potential enrollee desires.

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

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

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

☐ the State

☐ State contractor

Please specify:

☒ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The State seeks a waiver of section 1932(a)(3) of the Act, which requires states to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. The State will ensure this lack of choice of PAHP is not detrimental to beneficiaries ability to access services. Beneficiaries will have choice of providers through the PAHP.

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Outreach activities may be conducted by the PAHP. The PAHPs' outreach materials are informational in nature. The PAHPs' materials (i.e., flyers or other informational brochures) inform the potential enrollees about the programs and services that are available through the PAHPs, including the MI Choice program. MDHHS reviews and approves each flyer or brochure before its use.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

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

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

Broker name:

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:

The waiver agencies enter information related to the Nursing Facility Level of Care Determination Tool into the State's NFLOC system. The State's NFLOC system determines whether the individual meets nursing facility level of care. If nursing facility level of care is met, the waiver agency enters a MI Choice enrollment record into CHAMPS when the waiver agency determines the individual requires MI Choice Waiver services. MDHHS reviews a statistically significant sample of LOCDs entered in to the NFLOC system. MDHHS will provide CMS with a semi-annual report of the findings of this review with results presented overall across all the state's LTSS programs and broken out specifically for the MI Choice waiver. MDHHS makes the determination of Medicaid Eligibility for individuals who do not have Medicaid prior to MI Choice enrollment. When MDHHS determines the individual is eligible for Medicaid, the enrollment is completed in CHAMPS.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a

voluntary basis in Section A.I.E.

☐ This is a **new** program.

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

☐ This is an **existing program** that will be expanded during the renewal period.

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

☐ 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 ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☐ The 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.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

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 enrollees 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.

- **i.** ☒ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

  Please describe the reasons for which enrollees can request reassignment

  The waiver agency may request a transfer based on participant preference or request.

- **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 PCCMs caseload.

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Steps in Determining Nursing Facility Level of Care (NFLOC)
1. An applicant calls one of his/her local waiver agencies asking about MI Choice.
2. Waiver agency uses the MI Choice Intake Guidelines (MIG) tool to determine the appropriateness of a face-to-face encounter.
3. For applicants who appear eligible for MI Choice from the MIG and request enrollment in MI Choice, a waiver agency schedules a face-to-face meeting with the applicant within 7 days of completion of the MIG or place the applicant on its waiting list.
4. Persons placed on the waiting list are provided adequate notice and information regarding the Medicaid Fair Hearings process.
5. A supports coordinator (a registered nurse or social worker) employed by the waiver agency visits the applicant and conducts the NFLOC determination. This process occurs at the meeting scheduled in step 3 or when the applicant reaches the top of the waiting list. The information from the NFLOC tool is entered into the State's NFLOC system, which then determines if the individual meets nursing facility level of care. The supports coordinator is notified that the individual does or does not meet NFLOC. After the LOCD has been entered into CHAMPS, a statistically significant random sample of LOCD records is pulled for MDHHS review of whether the assessment was conducted correctly. Denials of level of care are also reviewed by MDHHS.

6. Applicants who meet NFLOC criteria follow this process:
a. Supports coordinator provides information regarding options for receiving Long Term Care.
b. Supports coordinator provides a Freedom of Choice form that indicates the applicant meets NFLOC criteria and asks the applicant to specify their preferred option for receiving Long Term Care. The Freedom of Choice form is explained to the applicant and signed by the supports coordinator and the applicant or applicant’s representative.
c. If the applicant chooses MI Choice, the supports coordinator may begin the MI Choice enrollment process.
d. If the applicant does not choose MI Choice, the supports coordinator provides contact information for their preferred option, and may assist the applicants with the process of contacting the provider.
7. Applicants who do not meet nursing facility level of care criteria follow this process:
a. Supports coordinator provides the applicant with adequate notice that includes information on how to request a Medicaid Fair Hearing, and how to request an immediate review.
b. Supports coordinator provides the applicant with information regarding options for receiving services in the community.
c. Supports coordinator provides a Freedom of Choice form that indicates the applicant does not meet NFLOC criteria. The Freedom of Choice form is explained to the applicant and signed by the supports coordinator and the applicant or applicant’s representative.
d. Supports coordinator may provide contact information for other programs for which the applicant may qualify and may assist the applicant with contacting these programs.

Steps to Enrolling in MI Choice
1. Once the NFLOC determination is made, confirms the applicant meets NFLOC criteria, and the Freedom of Choice form is completed, the supports coordinator may begin the assessment process.
a. MDHHS requires MI Choice initial assessments to be completed by a team of supports coordinators comprised of both a registered nurse and a social worker.
b. Prior to scheduling the assessment, the waiver agency will notify the applicant of the option to have a supports broker and other informal supports present during the assessment.
c. The assessment may occur immediately after the NFLOC determination or be scheduled for a later date, according to participant preference.
2. During the assessment, the supports coordinators ascertain whether the applicant has been approved for Medicaid, or whether the applicant needs to apply for Medicaid.
a. Applicants with approved Medicaid move to the next step.
b. All other applicants will be asked information to assess potential eligibility for Medicaid. When applicable, and authorized by the applicant, the supports coordinators may assist the applicant with completing a Medicaid application, gathering verification documents, and submitting the application to MDHHS. This process is not usually completed in a single visit.
3. From data gathered during the assessment process, the supports coordinators may begin developing a person-centered service plan with the applicant. This process will assist with identifying the need for at least one MI Choice service in addition to supports coordination. This process may occur at a subsequent meeting and does not have to occur on the same day as the assessment.
4. Applicant will approve or disapprove services included on the person-centered service plan. The supports coordinator will assist the applicant with identifying MI Choice services and service providers, frequency, duration, other interventions, goals, and desired outcomes to include on the person-centered service plan.
5. Waiver agency will notify the Michigan Department Health and Human Services (MDHHS) of the applicant’s desire to enroll in MI Choice and provide the desired MI Choice start date, and when applicable, provide the completed Medicaid application.
6. MDHHS eligibility specialists determine Medicaid financial and medical eligibility.
7. When the Medicaid eligibility determination has been made by MDHHS, the waiver agency submits the enrollment record

into the CHAMPS system.
8. If the applicant is determined to not be eligible for Medicaid, MDHHS provides Adverse Action notices to applicants according to established policy along with a Request for an Administrative Hearing form.
9. Waiver agency may begin services once the person-centered service plan is developed, but MDHHS will not generate a capitation payment until the PAHP processes the MI Choice waiver online enrollment in CHAMPS.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ 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.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. Assurances For MCO or PIHP programs. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

These assurances apply to MI Choice PAHPs.

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

☐ 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 States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is [ ] days (between 20 and 90).

☐ The States timeframe within which an enrollee must file a **grievance** is [ ] days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

- ☐ the State
- ☐ the States contractor.

  Please identify:
- ☐ the PCCM
- ☒ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs 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 MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☐ 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.

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the

areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:

- There must be at least one checkmark in each column under Evaluation of Program Impact.
- There must be at least one check mark in one of the three columns under Evaluation of Access.
- There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
MI Choice	PAHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: MI Choice

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

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

Activity Details:

Some of the MI Choice Waiver agencies are accredited by either NCQA or CARF. The accreditation information may be viewed on the MDHHS MI Choice website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4857_5045-16263--,00.html

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☒ **Other**

Please describe:

CARF

c. ☒ **Consumer Self-Report data**

Activity Details:

1) MDHHS has implemented a statewide participant survey tool used to gather feedback on satisfaction of the quality of care and quality of life from the participants' perspectives. Each participant is given the survey by a third party vendor. The vendor compiles the reports and identifies areas that need improvement. Data is also shared with MDHHS who then reviews the data looking for trends or issues that may be addressed by MDHHS through a statewide quality improvement project.

2) MDHHS contracts with an EQRO with qualified reviewers who annually conduct a Clinical Quality Assurance Review (CQAR) to determine the waiver agency's adherence to the MI Choice clinical requirements. MDHHS conducts a biennial Administrative Quality Assurance Review (AQAR) to determine whether waiver agency policies and procedures comply to State and Federal requirements. Both of these reviews include visits to participant homes. At that time, participants self-report information about their quality of care. MDHHS uses this data to assess the effectiveness of the care received from the waiver agency and also uses it to determine areas in need of improvement.

3) A leadership group composed of consumers, advocates and waiver agency staff organized into the MI Choice Person Focused Quality Management Collaboration (QMC). A MI Choice participant currently serves as the QMC chairperson and leads each meeting. The purpose of the QMC is to include consumers and advocates in the development and review of MI Choice quality management activities. The QMC provides a venue where consumers and advocates can review a variety of quality outcomes, identify areas that need improvement, develop strategies for remediation of service delivery, and recommend improvements to the Michigan Medicaid service delivery system. The QMC allows the provision of meaningful input by consumers and advocates during the implementation of person-centered planning and self-determination care options that increase participant satisfaction with services and supports.

☒ **CAHPS**

Please identify which one(s):

HCBS Survey

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

The state assures quality in the services that are covered by the selective contracting program as identified in Appendices C and H of the §1915(c) waiver. Appendix C details the services, provider qualifications, credentialing standards, and provider training. Appendix H details the quality improvement strategy for the MI Choice program. MDHHS originally selected the selective contracting providers (waiver agencies) through a Request for Proposal process that included all of the requirements indicated in Appendix C. All other service providers are designated through a contract between the waiver agencies and the direct service providers.

To ensure that providers continue to meet requirements, MDHHS uses the MI Choice Site Review Protocol (MICSRP) to assess the performance of waiver agencies and assure that services covered by the selective contracting program are performed in accordance with waiver requirements included in their contracts. MDHHS developed the MICSRP with input from waiver agencies, participants, advocates, the Area Agency on Aging Association, and other stakeholders. MDHHS updates the MICSRP biennially or more frequently if needed to incorporate general improvements, policy changes, CMS initiatives, and MDHHS priorities.

The MICSRP has two parts, the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR) that also includes a participant home visit protocol. MDHHS staff developed a scoring system and algorithms to weight each standard in the MICSRP. This system allows MDHHS staff to calculate compliance equitably for each waiver agency, based on data obtained from the AQAR and CQAR, regardless of sample size.

The AQAR focuses on assuring that each waiver agency has policies and procedures consistent with waiver requirements. MDHHS staff completes the AQAR biennially for each waiver agency. During the on-site AQAR, MDHHS staff examines waiver agency policies and procedures, contract templates, financial systems, claims accuracy, and Quality Management Plans in detail seeking evidence of compliance to the AQAR standards.

MDHHS has qualified reviewers who complete the CQAR. The reviewers evaluate the waiver agency's enrollment, assessment, level of care evaluations, care planning, and reassessment activities annually seeking evidence of compliance to the CQAR standards. The reviewers collect and review both qualitative and objective data, and evaluate the assessment and supports coordinators' actions to assure that the plan of service includes every participant need identified in the assessment. The reviewers determine the waiver agency's level of compliance to the standards included in the MICSRP. The reviewers send an initial report of all non-evident findings and a listing of any findings that require immediate remediation. Any findings related to the health and welfare of an enrolled participant would require immediate remediation. The immediate remediation is due within two weeks. Waiver agencies also are given the opportunity to provide additional documentation for any non-evident findings due within two weeks. The reviewers examine submitted documentation to assure the waiver agency addressed all items that required immediate remediation. Some scores may be revised if documentation was overlooked or missing during the initial review.

Both the AQAR and CQAR review elements that make up the performance measures in each appendix of the §1915(c) waiver. The AQAR and CQAR include reviews of the following:

1) Participant access and level of care determination
2) Participant-centered service planning
3) Service delivery
4) Provider capacity and capabilities
5) Participant safeguards related to health and welfare
6) Participant rights and responsibilities
7) Participant outcomes and satisfaction
8) System performance

Once AQAR or CQAR data is complete, MDHHS compiles reports to send to the waiver agency. Each report includes a summary of successes in practice and deficiencies in practice.

MDHHS divides the deficiencies into citations and recommendations based upon algorithms for each standard. The waiver agency has 30 days to respond to the citations with a corrective action plan. The corrective action plan may also include actions to address recommendations, but MDHHS does not mandate this. MDHHS works with the waiver agency to assure the corrective action plan will produce quality improvements. Once the waiver agency and MDHHS agree on the final corrective action plan, MDHHS sends approval and written documentation detailing the plan to the waiver agency. MDHHS applies algorithms to final AQAR and CQAR data to determine an overall quality score for each waiver agency and statewide.

More detail on the MI Choice Quality Improvement System is identified in Appendix H of the §1915(c) waiver.

MDHHS also reviews aggregate reports on various aspects of the MI Choice program including results of CQARs and AQARs, assessment data including Quality Indicators (QI) that measure 20 Participant Health Status Outcomes, enrollment and disenrollment data, and critical incident reports. Data reports are used to discover areas needing follow-up, research or improvement.

MDHHS developed the Critical Incident Reporting system with assistance from the QMC and other stakeholders. MDHHS requires each waiver agency to report all critical incidents in the web-based Critical Incident Reporting System. MDHHS defines procedures for reporting critical incidents in the Supports Coordination Service Performance Standards and Waiver Operating Criteria, which is an attachment to the waiver agency contract with MDHHS. Waiver agencies manage critical incidents at the local level by identifying and evaluating each incident. Supports coordinators then initiate strategies and interventions approved by participants to prevent further incidents and follow-up, track and compile mandatory critical incident reports.

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

MDHHS reviews appeal and decision summaries as they become available. MDHHS keeps track of the types of appeals, whether decisions were affirmed or reversed, and checks for trends or issues.

e. ☐ **Enrollee Hotlines**

Activity Details:

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

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

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

Activity Details:

For details on the CQAR, AQAR, and MICSRP processes, please refer to box d above. MDHHS will arrange for an independent assessment of the MI Choice program and will submit the findings prior to renewing the waiver program.

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

Activity Details:

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

Activity Details:

Each waiver agency uses an open bid process to contract with qualified providers in their service area that are willing to furnish MI Choice services. MDHHS requires each waiver agency to have a provider network with capacity to serve at least 125% of their monthly slot utilization for each MI Choice service, and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from the Department. This assures network capacity as well as choice of providers.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

To ensure that providers continue to meet requirements, MDHHS uses the MI Choice Site Review Protocol (MICSRP) to assess the performance of waiver agencies and assure that services covered by the selective contracting program are performed in accordance with waiver requirements included in their contracts. MDHHS developed the MICSRP with input from waiver agencies, participants, advocates, the Area Agency on Aging Association, and other stakeholders. MDHHS updates the MICSRP biennially or more frequently if needed to incorporate general improvements, policy changes, CMS initiatives, and MDHHS priorities.

The MICSRP has two parts, the Administrative Quality Assurance Review (AQAR) and the Clinical Quality Assurance Review (CQAR) that also includes a participant home visit protocol. MDHHS staff developed a scoring system and algorithms to weight each standard in the MICSRP. This system allows MDHHS staff to calculate compliance equitably for each waiver agency, based on data obtained from the AQAR and CQAR, regardless of sample size.

The AQAR focuses on assuring that each waiver agency has policies and procedures consistent with waiver requirements. MDHHS staff completes the AQAR biennially for each waiver agency. During the on-site AQAR, MDHHS staff examines waiver agency policies and procedures, contract templates, financial systems, claims accuracy, and Quality Management Plans in detail seeking evidence of compliance to the AQAR standards.

MDHHS has qualified reviewers who complete the CQAR. The reviewers evaluate the waiver agency's enrollment, assessment, level of care evaluations, care planning, and reassessment activities annually seeking evidence of compliance to the CQAR standards. The reviewers collect and review both qualitative and objective data, and evaluate the assessment and supports coordinators' actions to assure that the plan of service includes every participant need identified in the assessment. The reviewers determine the waiver agency's level of compliance to the standards included in the MICSRP. The reviewers send an initial report of all non-evident findings and a listing of any findings that require immediate remediation. Any findings related to the health and welfare of an enrolled participant would require immediate remediation. The immediate remediation is due within two weeks. Waiver agencies also are given the opportunity to provide additional documentation for any non-evident findings due within two weeks. The reviewers examine submitted documentation to assure the waiver agency addressed all items that required immediate remediation. Some scores may be revised if documentation was overlooked or missing during the initial review.

Both the AQAR and CQAR review elements that make up the performance measures in each appendix of the §1915(c) waiver. The AQAR and CQAR include reviews of the following:

1) Participant access and level of care determination
2) Participant-centered service planning
3) Service delivery
4) Provider capacity and capabilities
5) Participant safeguards related to health and welfare
6) Participant rights and responsibilities
7) Participant outcomes and satisfaction
8) System performance

Once AQAR or CQAR data is complete, MDHHS compiles reports to send to the waiver agency. Each report includes a summary of successes in practice and deficiencies in practice. MDHHS divides the deficiencies into citations and recommendations based upon algorithms for each standard. The waiver agency has 30 days to respond to the citations with a corrective action plan. The corrective action plan may also include actions to address recommendations, but MDHHS does not mandate this. MDHHS works with the waiver agency to assure the corrective action plan will produce quality improvements. Once the waiver agency and MDHHS agree on the final corrective action plan, MDHHS sends approval and written documentation detailing the plan to the waiver agency. MDHHS applies algorithms to final AQAR and CQAR data to determine an overall quality score for each waiver agency and

statewide.

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

Activity Details:

MDHHS establishes a Quality Management Plan (QMP) biennially, which includes statewide goals and strategies identified in part by the consumer-run Quality Management Collaborative. The QMP focuses on meeting CMS assurances and requirements for protecting the health and welfare of waiver participants, MDHHS contract requirements, and targeted participant outcome improvement goals. MDHHS requires each waiver agency to have its own QMP and reviews them biennially. MDHHS guides, prompts, and assists each waiver agency in preparing and updating its QMP based on individual agency and provider network results from compliance reviews, participant outcomes, consumer survey results, complaint history, and other performance based outcomes. Each waiver agency includes the MDHHS required goals in its QMP and adds its own unique quality improvement goals, or self-targeted quality improvement strategies, including service provider performance requirements and administrative improvements. Performance Improvement Projects include both clinical and nonclinical aspects of the program.

☐ **Clinical**

☐ **Non-clinical**

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

Activity Details:

The PAHP quality assessment and performance improvement (QAPI) programs include those performance measures specified by MDHHS related to quality of life, rebalancing, and community integration activities.

☐ **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**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

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

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

t. ☒ **Other**

Activity Details:

MDHHS has a well established quality improvement strategy (QIS) in place for the MI Choice program as detailed in the 1915(c) waiver application. MDHHS designed the strategy to assess and improve the quality of services and supports managed by the 20 waiver agencies that administer MI Choice.

PAHPS do not conduct marketing or use PCPs and specialists.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

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

○ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please

explain why.

- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

1. Consumer Self-Report Data
MDHHS has conducted participant surveys to gather feedback on their satisfaction with the quality of care and quality of life. Waiver agencies have reviewed the surveys to identify any problem areas that are in need of improvement. MDHHS also reviewed survey data and worked with the waiver agencies to make improvements as needed. Participant surveys have been conducted twice per year in January and June. Results are shared with waiver agencies. Results for the most recent aggregated data for the participant surveys for each waiver agency are posted on the MI Choice website.

The Clinical Quality Assurance Review (CQAR) team has made annual visits to participants' homes. During these home visits, participants were offered an opportunity to report information about their quality of care and experience with the program. This is reported to MDHHS, and MDHHS includes this information in the CMS-372 report within other performance measure information. Results of the CQAR reviews are also posted on the MI Choice website.

Quality Management Collaborative meetings were held on a quarterly basis and there were also QMC Steering Committee conference calls at least once per month, and QMC participant-only meetings are every two months. These meetings included program participants, advocates and waiver agency representatives. This is a venue for MDHHS to notify stakeholders of ideas, potential program changes, and also for participants and advocates to provide feedback on program effectiveness or areas that need improvement. Conference calls have been held more often than monthly as needed.

2. Data Analysis
Administrative Quality Assurance Reviews (AQAR) and Clinical Quality Assurance Reviews (CQAR) have been performed by MDHHS and the CQAR team to obtain data related to the performance measures indicated in the 1915(c) waiver for MI Choice. AQAR functions are conducted on a bi-ennial basis, and CQAR functions conducted on an annual basis. Information was compiled and analyzed using algorithms and other scoring criteria for the various topic areas such as enrollment, assessment, level of care evaluations, person-centered service plans, financial accountability, policies and procedures, critical incidents, etc. Results and deficiencies were then sent to the waiver agencies to determine corrective action that needed to be taken. These reviews have occurred throughout the five years of the approved Waiver. There have been no known major system-wide problems. Results from AQAR and CQAR reviews have been included in the CMS-372 report in the performance measure reporting. Results of the CQAR reviews are also posted on the MI Choice website.

MDHHS has also reviewed all appeal and decision summaries from the State Fair Hearings process related to the program and required corrective action from waiver agencies as needed.

3. Independent Assessment
The EQRO and CQAR team has conducted independent assessment of the MI Choice program. MDHHS has contracted with an External Quality Review Organization (EQRO) to complete reviews of the program. The EQRO is responsible for evaluating information for the various performance measures as listed under the 1915c waiver. These evaluations have been included in the annual CMS-372 reports as well as the IPG report. Results of the reviews are also posted on the MI Choice website.

4. Network Adequacy Assurance by Plan
MDHHS has reviewed each waiver agency's provider network based on program requirements several times within the past five years. The agencies have submitted information to MDHHS for review and approval. MDHHS has notified the agencies when there are deficiencies in the provider network. There have been no known major system-wide problems. Some waiver agencies have requested rural exceptions from MDHHS for certain services, and these exceptions have been granted. MDHHS has this information saved in electronic files and can be retrieved as needed. A rural exception has been granted to Region 3B Area Agency on Aging, AAA Northwest Michigan, and AAA Western Michigan for the Adult Day Health service.

5. On-Site Reviews
CQAR and AQAR have conducted on-site reviews of the waiver agencies to ensure contract requirements are met, the agencies are properly providing services to participants, critical incidents are being reported as required, etc. Results of the site reviews were compiled and provided to the waiver agencies so corrective action could be taken as needed. There have been no known major system-wide problems. Results are included with the performance measures in the CMS-372 report annually. Results of the CQAR reviews are also posted on the MI Choice website.

6. Performance Improvement Projects
MDHHS has developed Quality Management Plans, which include goals and strategies (indicators) to assure quality program operations and service delivery. Waiver agencies have utilized the Quality Management Plans as a basis for their own quality management/improvement plans. Quality Management Plans are done every two years. Alternating years include MDHHS receiving updates from waiver agencies as to progress that has been made. The waiver agencies submitted their plans to MDHHS for review and approval. The Quality Management Plan indicators are shared with the Quality Management Collaborative which includes MI Choice participants. Some waiver agencies are also NCQA accredited and have performance projects related to their NCQA accreditation. The information can be provided to CMS as needed, but each waiver agency has their own projects and plans.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Aged, Blind and Disabled - Nursing Facility Level of Care	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2016	09/30/2017	10/01/2017	03/31/2018
Enrollment Projections for the Time Period*	10/01/2018	09/30/2019	10/01/2019	09/30/2020

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Nursing Services	☐	☐	☒	
Home Delivered Meals	☐	☐	☒	
Environmental Acessibility Adaptations	☐	☐	☒	
Goods and Services	☐	☐	☒	
Training	☐	☐	☒	
Community Transportation	☒	☐	☒	
Adult Day Health	☐	☐	☒	
Personal Emergency Response System	☐	☐	☒	
Chore Services	☐	☐	☒	
Respite	☐	☐	☒	
Private Duty Nursing	☐	☐	☒	
Counseling Services	☐	☐	☒	
Fiscal Intermediary	☐	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Supports Coordination	☐	☐	☒	
Specialized Medical Equipment and Supplies	☐	☐	☒	
Community Living Supports	☐	☐	☒	
Community Health Worker	☐	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States 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 States submitted CMS-64 forms.

Signature: Kathleen Stiffler

State Medicaid Director or Designee

Submission Date: Jun 12, 2019

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Brian Barrie

c. Telephone Number:

(517) 335-5131

d. E-mail:

BarrieB@michigan.gov

e. The State is choosing to report waiver expenditures based on

◉ **date of payment.**

○ **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

b. ☐ The State provides additional services under 1915(b)(3) authority.

c. ☐ The State makes enhanced payments to contractors or providers.

d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

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

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **MCO**

b. ☐ **PIHP**

c. ☒ **PAHP**

d. ☐ **PCCM**

e. ☐ **Other**

Please describe:

The PAHP is paid on a risk basis.

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

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

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.

1. ☐ **Year 1: $** ____ **per member per month fee.**
2. ☐ **Year 2: $** ____ **per member per month fee.**
3. ☐ **Year 3: $** ____ **per member per month fee.**
4. ☐ **Year 4: $** ____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ **Other reimbursement method/amount.**
$ ____
Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☒ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Retrospective year 1 (R1) represents state fiscal year (SFY) 2017 covering the time period from October 1, 2016 to September 30, 2017, with retrospective year (R2) representing a 6-month time period from October 1, 2017 to March 31, 2018. As the waiver is being renewed prior to the end of the currently approved waiver period, R2 reflects only 6 months of actual experience. Historical member months summarized from the monthly data process have been reported for R1 and R2. The member months were developed based upon the number of capitation payments made for MI Choice participants during the retrospective time periods. We have included an adjustment to future enrollment based on a 1 percent annualized trend for future periods.

d. ☒ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

None.

e. ☒ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

State fiscal year (SFY), which is the same as the Federal fiscal year (FFY).

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

a. ☒ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

The current 1915(b) waiver application was used to detail the list of covered services under the MI Choice Waiver program. An addition was made for the new Community Health Worker service that is being added in this waiver renewal. All services are identified as 1915(c) waiver services being paid through a capitated reimbursement methodology.

b. ☒ **[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.

There have been no services excluded from the cost-effectiveness analysis.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Nursing Services	☐	☐	☐	☐	☐	☒	☐
Home Delivered Meals	☐	☐	☐	☐	☐	☒	☐
Environmental Acessibility Adaptations	☐	☐	☐	☐	☐	☒	☐
Goods and Services	☐	☐	☐	☐	☐	☒	☐
Training	☐	☐	☐	☐	☐	☒	☐
Community Transportation	☐	☐	☐	☐	☐	☒	☐
Adult Day Health	☐	☐	☐	☐	☐	☒	☐
Personal Emergency Response System	☐	☐	☐	☐	☐	☒	☐
Chore Services	☐	☐	☐	☐	☐	☒	☐
Respite	☐	☐	☐	☐	☐	☒	☐
Private Duty Nursing	☐	☐	☐	☐	☐	☒	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Counseling Services	☐	☐	☐	☐	☐	☒	☐
Fiscal Intermediary	☐	☐	☐	☐	☐	☒	☐
Supports Coordination	☐	☐	☐	☐	☐	☒	☐
Specialized Medical Equipment and Supplies	☐	☐	☐	☐	☐	☒	☐
Community Living Supports	☐	☐	☐	☐	☐	☒	☐
Community Health Worker	☐	☐	☐	☐	☐	☒	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☐ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☒ **Other**
Please explain:

The per member per month (PMPM) state administrative cost that was filed with the previously approved waiver has been maintained in this waiver renewal and adjusted the aggregate expense to align with current membership. The distribution of administrative expenses reflects a distribution amongst the reported categories consistent with the previously approved waiver.

Administrative expenses were developed based on the percent of total historical state administrative costs associated with the MI Choice waiver program. We applied a percentage to the state's expenses which developed PMPM amounts in line with previously filed values. Experience reported in the current 1915(b) waiver filing was reviewed and allocated the administrative expenses for the R1 and R2 time periods across Operations and Salaries, Employee Benefits, Actuarial Costs consistent with the current filing.

The Supports Coordination/Case Management services were transitioned to a waiver service during the current waiver period. Therefore, expenses associated with these functions are not reflected in the state administrative cost component, rather they are included in the capitation rates paid to the MI Choice waiver agents. The MI Choice waiver agents report the Supports Coordination/Case Management services in their encounter data.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

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

b. ☐ **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☒ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☐ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☒ **The State provides stop/loss protection**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

No specific stop/loss coverage is provided to MI Choice waiver agents for high cost members, however, the state does operate a risk pool to re-distribute capitation revenue for members above identified levels. Effective October 1, 2015, MDHHS began maintaining a cost-neutral risk pool for high cost claimants in the MI Choice program. The risk pool was introduced to address the high cost nature of certain members in the MI Choice population and the potential for the prevalence of these beneficiaries to vary between waiver agents. To the extent a waiver agent provides services to a member who qualifies for payment from the risk pool, the waiver agent receives additional reimbursement within the capitation rate structure. Waiver agents who do not have any members which qualify for payment do not receive additional payment. The risk pool adjustments are specific to higher needs members as these populations have shown the potential for larger variances in member costs. The development of the risk pool does not impact the capitation rate development process.

d. ☒ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☒ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

Document

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

i. MDHHS will be withholding a percentage of the capitation payments and will pay this out to PAHPs after the end of the year based on their CQAR/AQAR performance indicators. The criteria for the awards are communicated to the PAHPs each year. The costs related to the withhold payment represent 1 percent of the capitation payment amount.

ii. For each contract year, performance bonus incentives are withheld from the capitation payments for the respective PAHPs. The amount withheld for each year of the waiver period is a percentage of the capitation payment. The incentive costs are calculated as a percentage of the capitated costs.

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

The incentive payments have been broken out in the Appendix D spreadsheets for the purposes of determining cost effectiveness. The incentive payments reflect a 1% withhold that is applicable to the MI Choice waiver agent capitation payments. As the entirety of the capitation payments made to MI Choice waiver agents are 1915(c) waiver services, the incentive payments reflect 1% of the capitation rates, which equals the sum of the 1915(c) waiver service costs plus incentive cost columns in the Appendix D workbook.

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

Document:

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

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

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

1. ☐ **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using**

actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

The actual trend rate used is:

Please document how that trend was calculated:

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

   i. ☒ **State historical cost increases.**
   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   The State is using 1915(c) services instead of State Plan services due to this being a concurrent (b)/(c) waiver.

   SFY 2016-2018 actual capitation rate changes along with proposed changes for SFY 2019 were utilized for developing the cost increases from the base years to P1 through P5. The waiver agent encounter data, submitted waiver agent survey data, and historical capitation rates were the primary sources used by the actuary for determining trend assumptions for the prospective periods for this waiver request. The State considered historical year over year trends in developing trend estimates and also changes to the waiver program, consistent with the development of capitation rates. The actuary utilized a linear regression looking at historical experience on a rolling twelve-month basis. For the prospective time periods (P1 to P2, P2 to P3, P3 to P4 and P4 to P5), the State assumed an overall 4.0% annual trend. This trend rate considers multi-year projections as this constitutes a 5-year waiver renewal. No additional program changes were reflected in this projection and the cost increase calculation considers increases for future utilization and cost per service

   ii. ☐ **National or regional factors that are predictive of this waivers future costs.**
   Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**
   Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
   i. Please indicate the years on which the utilization rate was based (if calculated separately only).
   ii. Please document how the utilization did not duplicate separate cost increase trends.

Appendix D4 Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☒ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

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

For the list of changes above, please report the following:

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

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

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

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

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

iii. ☐ Changes brought about by legal action:
Please list the changes.

For the list of changes above, please report the following:

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

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

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

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

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

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

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

D. ☐ Other

Please describe

v. ☒ Other
Please describe:

The State is using 1915(c) services instead of State Plan services due to this being a concurrent (b)/(c) waiver.

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

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

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

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

1. ☒ No adjustment was necessary and no change is anticipated.
2. ☐ An administrative adjustment was made.
   i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
   Please describe:

   ii. ☐ Cost increases were accounted for.
      A. ☐ Determine administration adjustment based upon an approved contract or cost allocation

plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

Please describe:

D. ☐ Other
Please describe:

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

Section D: Cost-Effectiveness

Part I: State Completion Section

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

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

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

i. **A. State historical 1915(b)(3) trend rates**

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

B. State Plan Service trend

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

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

A 4 percent increase was applied to incentive costs and the incentive costs represent the 1 percent withhold from capitation rates.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- - If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
  - Once the States 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 contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. ☐ Other

Please describe:

1. ☐ No adjustment was made.

2. ☒ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

The 4% trend/inflation increases applied for P1-P5 took into consideration historical MI Choice capitation rate changes for SFY 2016 though SFY 2018 and proposed changes for SFY 2019. Changes have ranged from a 2.0% decrease to 6.1% increase during this time. We have considered a reasonable growth rate in unit cost and utilization for the services covered under the MI Choice waiver program.

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

Using R2 as the historical basis, as established by the Appendix D workbook template, P1 costs were projected by applying a 4 percent increase to the 1915(c) waiver costs, which represents the adjustment for the capitation payments for SFY 2019. As the SFY 2019 capitation rates are not yet certified, a 4 percent adjustment has been utilized from the current year based on historical changes in the capitation rates over the past two fiscal years. The incentive cost increase is consistent with the 1915(c) waiver cost increase as the incentive costs represent the 1 percent withhold from the capitation rates. The 4 percent adjustment is held constant for P2-P5. Additionally, a trend of 3 percent is being applied to the state's administrative costs based on a review of Consumer Price Index (CPI) value.

The program adjustments noted in P1 and P2 represent the impact of removing the cost of community transitions from the MI Choice managed care program. We calculated that transition case rate payments represent approximately 0.3% of the historical overall capitation payments. Based on the timing of the waiver amendment being effective July 1, 2019, we applied 25% of the adjustment to P1 (for the last quarter) with the remainder of the adjustment reflected in P2.

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

Appropriate changes made on the D5. Waiver Cost Projection section flowed through to this section. Please note a column for 1915(c) waiver services has been included for purposes of this waiver submission.

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

Appropriate changes made on the D5. Waiver Cost Projection section flowed through to this section. Please note a column for 1915(c) waiver services has been included for purposes of this waiver submission.

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:

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 States explanation of cost increase given in Section D.I.I and D.I.J:

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 States explanation of utilization given in Section D.I.I and D.I.J:

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

Appendix D7 - Summary