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 Health Link	MI Health Link	MCO;	

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

MI Health Link

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):

The purpose of this waiver amendment is to revise the cost effectiveness benchmark for calendar year 2025. Adjustments have been made to values associated with the CY 2025 time period which are anticipated to maintain the cost effectiveness of the waiver. Changes have been made to Sections: services (added two services that are not new, but were not previously represented) D4, D5, D6 and D7 and the Financial workbook.

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.030.02.01

Waiver Number:MI.0019.R02.01

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: 01/01/25

Proposed Effective Date: (mm/dd/yy)

01/01/25

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 Health Link**

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.

For this waiver renewal, a notice (L 25-09) was distributed to the Tribal Chairs and Health Directors summarizing the proposed revisions on 03/7/2025 with a comment period through 04/21/2025. No comments 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).

The MI Health Link 1915 concurrent (b) and (c) Waivers were approved by the Centers for Medicare and Medicaid Services (CMS), effective January 1, 2015 to integrate care for Medicare-Medicaid beneficiaries in four regions (Upper Peninsula, Southwest Michigan, Macomb County and Wayne County.) The 1915(b) program authorized under section 1915(b)(1), 1915(b)(2), and 1915(b)(4) of the Social Security Act (the Act) allows Michigan to require mandatory enrollment of all individuals dually eligible for Medicare and Medicaid who choose to participate in MI Health Link, into the state's contracted managed care organizations for Medicaid state plan services and services approved under the 1915(c) waiver. The 1915(c) Home and Community Based (HCBS) Waiver is approved to serve individuals that are 65 and older and individuals with physical disabilities from ages 18-64 (note MI Health Link minimum age is 21.) The c-waiver provides HCBS for individuals who, absent the waiver, would require services in a nursing facility.

The Demonstration is governed by a Memorandum of Understanding and a 3-way contract between CMS, the State of Michigan, and the selected Medicare-Medicaid Plans known as Integrated Care Organizations that provide services to enrollees and carry out the waiver obligations. The 3-way contracts were executed on October 7, 2014 and enrollment began in March of 2015 and was phased in. During phase 1 eligible beneficiaries in two demonstration regions (Upper Peninsula and Southwest Michigan) were enrolled. During March and April 2015 only opt-in enrollments were effective. Passive enrollment in these two regions occurred in May and June 2015. Phase 2 began in May 2015 with 2 months of opt-in enrollment in the two remaining demonstration regions (Wayne and Macomb Counties.) Passive enrollments for these two regions occurred in July, August, and September 2015. Opt-in enrollment continued beyond phases 1 and 2 for all eligible individuals. There was no passive enrollment from October 2015 through May 2016 except in January of 2016. Monthly passive enrollment began in June of 2016 and continued through March of 2018. There was a moratorium on passive enrollment for the months of April 2018- July 2019 except for the months of May 2018 and June 2019 due to issues arising from systems conversions.

The C- Waiver provides participant self-direction opportunities and offers the following services: adult day program, respite, adaptive medical equipment and supplies, fiscal intermediary, assistive technology, chore services, environmental modifications, expanded community living supports, home delivered meals, individual directed goods and services, non-medical transportation, personal emergency response system, preventative nursing services, and private duty nursing. Community Transitions Services were included in the c-waiver until October 1, 2018 when CMS approved a 1915(i)State Plan Amendment. Vehicle modifications were pulled out from assistive technology to become its own unique service effective January 1, 2025 with approval of the c-waiver renewal. The goal of the waiver is to provide home and community-based supports and services to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life.
The MI Health Link HCBS Waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration (BPHASA), which is the Single State Agency. The first C-Waiver enrollment occurred in July 2015.

There were several changes to the demonstration that occurred during the first waiver period. Deemed enrollment was implemented in July of 2016 and a new passive algorithm was implemented in July of 2017 and again in August of 2019. The three way contract was amended in 2016 to strengthen care coordination requirements related to engaging enrollees and person centered care planning. In 2018 the three way contract was again amended to reflect revised requirements related to assessment deadlines, and Integrated Care Team Meetings and responsibilities. This amendment also expanded the allowable credentials of the Care Coordinator and Supports Coordinator role.

Additional changes occurred during the second waiver period. The demonstration end date was extended to 12/1/2023 and then again to 12/31/2025. The three-way contract ammendment effective 1/1/2022 introduced additional requirements to strengthen the care coordination framework including:

- Implementing care coordinator caseload requirements
- Implementing a deadline to risk stratify new members
- Implementing additional standards for automatically stratifying members as high risk
- Requiring more contact attempts for unable-to-reach members
- Implementing a standardized member assessment
- Requiring care coordinators have access to and are informed of all Adverse Benefit Determinations, including those made by First Tier, Downstream, and Related entities

The 2022 contract amendment also effectuated the change to utilizing MHL plan experience data in rate setting. Additionally, contract language was added to reflect the importance of the social determinants of health, health disparities and health equity, including as part of MHL plans' quality improvement efforts.

The COVID-19 Public Health Emergency began and concluded during the second waiver period and spanned the years 2020-2023. Many COVID-19 Time Limited Policies were implemented during this time period by MDHHS as a result. An initiative to temporarily provide Direct Care Workers providing certain in-person services to beneficiaries enhanced pay was implemented, and has continued to the present. MDHHS utilized an 1135 waiver, a State Plan Disaster Amendment and the MHL program utilized Appendix K authority to provide defined flexibilities for the HCBS population/providers during the Public Health Emergency. The COVID-19 PHE had an impact on how care and care coordination activities were delivered.

During the second waiver period, there were also changes to the contractual arrangements between Integrated Care Organizations and the PIHPs responsible for mental health and substance use disorder services. TMDHHS holds a contract with PIHPs to delivery specialty mental health and substance use disorder services for all Michigan Medicaid beneficiaries including those enrolled in MI Health Link. The three-way contract requires ICOs to offer PIHPs the first right of refusal for delivery of mental health and substance use disorder services that fall outside of specialty services. During the second waiver period, some PIHPs in some regions withdrew from their contracts with the ICOs. In these cases the ICO contracts directly with providers for these services. The second waiver period also saw changes to Medicaid services with the addition of expanded dental benefit coverages, and addition of Doula and community health worker services.

The first year of the proposed third waiver period will be the final year of the MI Health Link Financial Alignment Initiative. MDHHS worked to collect stakeholder feedback during the 2nd waiver period to inform the demonstration extension policies as well as the planned program transition. Effective 1/1/2026 this program will transition to a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) program.

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 Health Link**

   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 Health Link**

   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 Health Link**

   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 Health Link**

   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 Health Link**

   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 Health Link**

   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 Health Link**

   d. ☐ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

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

   ☐ **MI Health Link**

   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 Health Link**

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:

MI Health Link is a program that will coordinate supports and services for individuals who are dually eligible for both Medicare and Medicaid programs and reside in any one of the four regions as indicated in Section A, Part I (D) of this application, and meet the following other eligibility criteria.

Included population:
Individuals who are aged and/or disabled, age 21 or older, eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, receiving full Medicaid benefits, and living in Region 1, 4, 7, or 9. Also included are individuals who are eligible for Medicaid through expanded financial eligibility limits associated with nursing facility placement or under a 1915(c) HCBS waiver.

Excluded population:
• Persons without full Medicaid coverage.
• Persons with Medicaid who reside in a State psychiatric hospital.
• Persons with commercial HMO coverage.
• Persons with Medicare Advantage through an employer.
• Persons disenrolled due to Special Disenrollment from Medicaid managed care.
• Persons incarcerated in a city, county, State, or federal correctional facility.
• Persons not living in a Demonstration region.
• Persons with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI).
• Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice waiver program.
• Persons residing in a State VA Home (as f June 1, 2018)
• Individuals under age 21 who participate in the Children's Special Health Care Services (CSHCS) program operating under the authority of Title V.

Medicare and Medicaid supports and services will be provided through managed care organizations called Integrated Care Organizations (ICOs) under a three-way contract with CMS and MDHHS. All enrolled individuals may receive Medicaid State Plan physical health care supports and services through the MI Health Link §1915(b) waiver. This MI Health Link §1915(b) waiver operates concurrently with the §1915(c) waiver called MI Health Link HCBS. The MI Health Link HCBS waiver offers home and community-based services (HCBS) to MI Health Link enrollees who are elderly and/or physically disabled, dually eligible for Medicare and Medicaid, and meet nursing facility level of care.

Under the entire MI Health Link §1915(b)/(c) waiver program, there are three capitation rate Tiers in which enrollees may be placed based on their needs. Tier 1 is for enrollees who reside in nursing facilities. Tier 1 enrollees will be given the choice of remaining in the nursing facilities or transitioning to the community and receiving home and community based services (HCBS). Tier 2 is for enrollees who participate in the MI Health Link HCBS waiver. Tier 2 enrollees would, if not for the provision of such home and community based services, require services in a nursing facility. The goal is to provide home and community based supports and services to participants using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. Tier 3 is for enrollees living in the community but are not eligible for MI Health Link HCBS. Michigan’s Nursing Facility Level of Care Determination (NFLOCD) tool will be used to determine in which Tier an enrollee will be placed. Tier 1 enrollees may transition to the MI Health Link HCBS waiver and would then become under the Tier 2 category.

The waiver is administered by the Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration, which is the Single State Agency. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations. CMS and MDHHS contract with Integrated Care Organizations (ICOs) to provide services to MI Health Link enrollees and carry out the waiver obligations. The ICOs are paid a monthly capitation rate for services rendered to MI Health Link enrollees. Each ICO must sign a provider agreement with MDHHS assuring that it meets all program requirements. ICOs may use written contracts meeting the requirements of 42 CFR 434.6 to deliver other services. Entities or individuals under contract or subcontract with the ICO must meet provider standards described elsewhere in the waiver application. Provider contracts or 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 Health Link §1915(b)/(c) waiver program enrollees also may receive supports and services for needs related to behavioral health, intellectual/developmental disability, or substance use disorders through the PIHPs under the Michigan 1115 Behavioral Health Demonstration. ICOs are required to work with the PIHPs to coordinate all supports and services for enrollees.

Participants enrolled in the MI Health Link HCBS waiver may not be enrolled simultaneously in another of Michigan’s §1915(c) waivers. Individuals who are enrolled in the Habilitation Supports Waiver through the PIHPs may receive services through the

MI Health Link 1915(b) waiver but are not permitted to participate in the MI Health Link HCBS waiver.

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 MCOs.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

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

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

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

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

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

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

Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

☒ **Procurement for MCO**

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

☐ **Procurement for PIHP**

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

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

For the MI Health Link program, MCOs are referred to as Integrated Care Organizations (ICOs).

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.

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

Program: " **MI Health Link.** *"*

☒ **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

Region 1 will have one MCO under a Rural Exception.

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

☒ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case

managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

The rural exception is operated in the following Michigan counties (Region 1): Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.

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

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

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

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

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

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

     ☐ **MI Health Link**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☒ **MI Health Link**
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 9	MCO	Aetna Better Health, AmeriHeatlh, HAP CareSource, Meridian Complete, Molina
Region 1	MCO	Upper Peninsula Health Plan
Region 7	MCO	Aetna Better Health, AmeriHeatlh, HAP CareSource, Meridian Complete, Molina
Region 4	MCO	Aetna Better Health, Meridian Complete Health

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Plan of Michigan

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 and associated counties:

Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

Region 4: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren

Region 7: Wayne

Region 9: Macomb

ICO Names:
AmeriHealth Michigan
Aetna Better Health of Michigan
Meridian Complete Health Plan of Michigan
HAP CareSource
Molina Healthcare of Michigan
Upper Peninsula Health Plan

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☒ **Other** (Please define):

Individuals who are aged and/or disabled, age 21 or older, eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, receiving full Medicaid benefits, and living in Region 1, 4, 7, or 9. Also included are individuals who are eligible for Medicaid through expanded financial eligibility limits associated with nursing facility placement or under a 1915(c) HCBS waiver.

Enrollees who are in need of services related to behavioral health (BH), intellectual/developmental disability (I/DD), and/or substance use disorders (SUD), will receive these services through the Michigan 1115 Behavioral Health Demonstration . Participants who are eligible for the Habilitation Supports Waiver (HSW) 1915(b)/(c) waiver, may choose to participate in the HSW instead of the MI Health Link HCBS 1915(c) waiver program, but will receive physical health supports and services through the MI Health Link 1915(b) waiver. The MI Health Link 1915(b) enrollees who are also enrolled in the HSW will also be able to receive all care coordination functions and requirements including use of the Care Bridge.

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.

Individuals under age 26 who participate in the Children's Special Health Care Services (CSHCS) program operating under the authority of Title V.

☒ **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):

- Persons without full Medicaid coverage.
- Persons with spend-down.
- Persons with Medicaid who reside in a State psychiatric hospital.
- Persons with commercial HMO coverage.
- Persons with Medicare Advantage through an employer.
- Persons disenrolled due to Special Disenrollment from Medicaid managed care.
- Persons incarcerated in a city, county, State, or federal correctional facility.
- Persons not living in a Demonstration region.
- Persons with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI).
- Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice waiver program.
- Persons residing in a State VA Home (as of June 1, 2018)
-Individuals with elected Hospice Benefits (if an existing enrollee elects hospice services, the enrollee may remain enrolled in the MHL program, and will only be disenrolled at the enrollee's request.

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:

To avoid duplication of services, persons enrolled in either the Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice 1915(b)/(c) waiver program may participate in the MI Health Link Program, but must first disenroll from PACE or MI Choice.

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:

Enrollees will have access to FQHCs either in the regional service area or out-of-network if an FQHC does not exist within the service area.

☐ 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):

This waiver program will enroll only those individuals who are age 21 and older, therefore EPSDT would not be applicable to this program.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

An enrollee may access the following services without prior authorization regardless of network affiliation:
- Emergency medical care
- Family planning services
- Immunization and communicable disease management from local Public Health Departments

An enrollee may access the following services without prior authorization from In-Network providers:
- Routine services offered by women's health specialists

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

ICOs will be required to provide for all services covered by Medicaid and Medicare and additional items or services indicated in this concurrent 1915(b)/(c) waiver application under a capitated model of financing. For additional details, refer to:

1) The Capitated Financial Alignment Model Memorandum of Understanding (MOU) between the Michigan Department of Health and Human Services (MDHHS) and the Centers for Medicare and Medicaid Services (CMS)
2)The Three-Way Contract for CMS, the State of Michigan, and ICOs

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 State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ 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 State's standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

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

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

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

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

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

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

Please describe:

Individuals with special health care needs are excluded from MI Health Link enrollment. This is defined as those individuals under age 26 who participate in the Children's Special Health Care Services (CSHCS) program operating under the authority of Title V.

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:

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:

e. ☐ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

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

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   c. ☐ Each enrollee is receives **health education/promotion** information.

      Please explain:

   d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   e. ☐ There is appropriate and confidential **exchange of information** among providers.
   f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
   g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   h. ☐ **Additional case management** is provided.

      Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

   i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part II: Access

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

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

Special Health Care Needs:The State defines individuals with special health care needs as including only children or those individuals participating in the Children's Special Health Care Services program. The MI Health Link (MHL) program will not be enrolling any individuals in these groups.
Care Bridge&Care Coordination Process:There is an extensive care coordination & continuity of care process for the MHL Program, as required by, and further detailed in,the MOU, the Three-Way Contract,& also the contract(s) between ICOs & PIHPs where applicable. Care coordination services are available to all enrollees.The care coordination process/framework, referred to as the Care Bridge, includes the following components.Through the Care Bridge,the members of the enrollee's care & supports team facilitate access to formal & informal supports & services identified in the enrollee's Individual Integrated Care & Supports Plan (IISCP).The Care Bridge includes an electronic Care Coordination platform which will support an Integrated Care Bridge Record(ICBR) to facilitate timely & effective information flow between the members of the care & supports team.The Care Bridge & related care coordination will provide for a person-centered approach that is consistent with the CMS model of care & Medicare & Medicaid requirements & guidance, the opportunity for enrollees to choose arrangements that support self-determination, appropriate access & information sharing for enrollees and treating providers, & medication review & reconciliation. The Care Bridge provides the functionality to facilitate coordination across the full continuum of the enrollee's services, supports, & providers. This includes facilitating access to appropriate community-based resources, with a focus on providing services in the most integrated setting & supporting transitions between care settings. The ICO Care Coordinator will offer care coordination services to the enrollee & will be required to jointly coordinate with the PIHP supports coordinator when the enrollee has received services through a PIHP within the last 12 months, or a newly enrolled person requests or is identified as having potential need for mental health, I/DD, or SUD needs. If the enrollee has need for long term supports & services (LTSS), the ICO Care Coordinator will collaborate with the enrollee's chosen LTSS supports coordinator. All ICOs and PIHPs have the capability to exchange data, Level 1 Assessments & requests for Level 2 Assessments, & the Level 2 Assessments themselves via the C-CDA Care Bridge. The ICOs & PIHPs are currently able to use V1.5 of MHL's C-CDA & MDHHS has developed a version of the C-CDA capable of encompassing the IICSP. Care coordination will include, at a minimum, the following steps within prescribed timeframes:1)an assessment process that includes an Initial Screening, a Level I Assessment, and if needed, a Level II Assessment;2) Meeting of the Integrated Care Team (ICT),as needed or as requested by the enrollee; 3)development of an IICSP based on the person-centered planning process; 4) ongoing care coordination, facilitating access to services& supports, monitoring &advocacy; 5) utilizing the Care Coordination platform to develop & maintain an ICBR.
The assessment process that must be completed for all enrollees:
1)Initial Screening using specified yes/no screening questions at the time of enrollment. Questions are related to historical & current service use. The purpose is to identify enrollees with immediate needs/prioritize enrollees needing a Level I Assessment conducted in person.
2)Level I Assessment: The ICO Care Coordinator will conduct this assessment using a standardized tool as directed by MDHHS to assess an enrollee's current health, welfare, functional needs & risks. This Assessment will serve as the basis for identifying need for Level II Assessment & referral.The Level I Assessment process may also include completing the Nursing Facility Level of Care Determination (NFLOCD)tool to determine whether an enrollee meets criteria for level of care as required for nursing facility residential placement or MHL HCBS waiver enrollment. More information about the NFLOCD tool may be found at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-103102--,00.html
3)Level II Assessment for enrollees identified as having a need for supports and services related to LTSS, BH,I/DD, SUD,or complex medical conditions. The Level II Assessment tools) are determined by MDHHS. If an individual has been assessed within the previous 12 months, the current assessment may be incorporated into the IICSP until the time of the annual reassessment or if the enrollee has a significant change in condition.
The enrollee must be reassessed at least annually, or sooner if there is a significant change in condition or upon request from the enrollee.
Integrated Care Team (ICT):An ICT will be offered to each enrollee. Membership will include the enrollee (to the extent he or she chooses to participate),his or her chosen allies,the ICO Care Coordinator,PCP,& LTSS Supports Coordinator,&/or PIHP Supports Coordinator(as applicable),& other individuals as appropriate. The role of the ICT is to participate in the person-centered planning process as directed by the enrollee,collaborate with other ICT members to ensure the person-centered planning process is maintained, assist the enrollee in meeting their goals,ensure the IICSP is monitored & implemented according to the enrollee's goals, review assessment or test results as needed, address transitions of care when a change between care settings occurs, ensure continuity of care, & monitor issues related to quality of care & quality of life. Refer to the 3 way contract for details regarding continuity of care transition requirements for different types of services such as primary care, DME, surgeries, chemotherapy & radiation, dialysis treatment, home health, nursing facility services,&others.

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: 10/01/14 (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	Health Services Advisory Group (HSAG)	CMS and MDHHS shall coordinate the ICO external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).		1)Encounter data validation 2)Administration or validation of consumer or provider surveys of quality of care 3)Secret Shopper Surveys

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
			1) Determine ICO compliance with federal Medicaid managed care regulations and quality standards, 2) Validation of performance measurement, 3) Validation of performance improvement projects.4) Validation of Network Adequacy	
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCM's response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to State's medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollee's PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of

qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

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

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

   Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

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

Please list types of indirect marketing permitted:

ICOs may participate in group marketing events and provide general audience materials. This includes but is not limited to general circulation brochures, pamphlets, newspaper articles, newspaper/magazine/billboard/radio/television advertisements, signs, non-ICO sponsored events, public transportation, mailings to general population, malls or commercial retail establishments, community centers, churches, non-ICO sponsored health fairs conducted in a public setting and provided to the general public. Some marketing and outreach may be conducted at local senior centers. ICOs must refer all potential enrollees to the enrollment broker for enrollment questions and information. Marketing materials must be approved by CMS and/or the State in accordance with federal regulations (42 CFR 438.104) or State policies, and as indicated in Michigan's Request for Proposals (RFP) for the MI Health Link program, the MOU, and/or the Three-Way Contract. Additional requirements will be described in the RFP, MOU and the Three-Way Contract and are also found in state-specific marketing guidance and model member materials issued by CMS and MDHHS and required for use by Medicare-Medicaid Plans (MMPs).

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

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

1. ☒ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

Direct marketing to individual enrollees or potential enrollees is prohibited.

ICOs are allowed to market their services to the general population within their entire service area. The ICO may not provide inducements through which compensation, reward, or supplementary benefits or services are offered to individuals to enroll or remain enrolled with the ICO. The State, and CMS in some instances, will review and approve marketing materials.

Marketing materials and processes will be reviewed during MI Health Link annual compliance reviews.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☒ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

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

Prevalent Language is defined as specific Non-English Languages that are spoken as the primary language by more than 5% of the ICO's enrollee population. Materials are translated into all Prevalent Languages. Oral translation is also required for all individuals.

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

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

Please describe the methodology for determining prevalent languages:

Prevalent language is defined as specific Non-English Languages that are spoken as the primary language by more than 5% of the ICO's enrollee population. Materials are translated into all Prevalent Languages. Oral translation is also required.

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):

Prevalent Language is defined as Specific Non-English Language that is spoken as the primary language by more than 5% of the potential enrollee/enrollee population. Enrollee materials are translated into all Prevalent Languages.

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

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

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

Please explain how the State defines "significant.":

b. ☒ The languages spoken by approximately 5.00 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.

ICOs and Michigan ENROLLS are required to have oral translation services available to any potential enrollees or enrollees. ICOs will be required to have oral interpretation services through in-person interpreters or via telephone through the Member Services toll-free telephone line.

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

Please describe:

The State, the Michigan Medicare Assistance Program (MMAP), and Michigan ENROLLS will provide factual and unbiased information about ICOs to potential enrollees and enrollees upon request. All enrollees are provided with basic information about the program and any enrollee rights and protections as required in 42 CFR 438.10.

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:

ICOs, Michigan's State Health Insurance Program (Michigan Medicare Assistance Program (MMAP)), or Michigan ENROLLS will distribute information to potential enrollees. The State may also distribute information. Potential enrollees may call 1-800-MEDICARE for information related to Medicare, but the beneficiary should contact Michigan ENROLLS for MI Health Link enrollment information.

☐ 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:

Michigan ENROLLS and possibly Michigan Medicare Assistance Program (MMAP).

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

Section A: Program Description

Part IV: Program Operations

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

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

a. Outreach

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

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

MDHHS staff have provided informational presentations to various stakeholder groups and regional forums which include provider organizations, potential enrollees and their representatives, advocates, and other individuals. These presentations and forums will be ongoing throughout the duration of the MI Health Link program. MDHHS has also developed a website which can be found at https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html

The enrollment broker (Michigan ENROLLS) does most of the outreach. Refer to Part IV(B)(Additional Information) for details. The Michigan Medicare Assistance Program may also conduct some outreach activities.

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: Michigan ENROLLS

Please list the functions that the contractor will perform:

☒ choice counseling

☒ enrollment

☒ other

Please describe:

Enrollment Counseling is provided by Michigan ENROLLS through telephone access, face to face meetings and information distributed in the mail. Michigan ENROLLS holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. The majority of enrollment contact is through the telephone.
All counselors hired by MAXIMUS, (dba Michigan ENROLLS) are given initial training that addresses the special needs of the Medicaid population. Michigan ENROLLS also has desk references that provide the reference information that can be utilized after training is completed. Michigan ENROLLS maintains a dedicated TTY phone line for hearing impaired. The field staff is also provided with the same training as the call center staff. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in assuring such services are available within the ICO network for new enrollees.

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

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

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

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

☒ 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 60 ◉ **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:

For details about the algorithm, refer to the Three-Way Contract.

☐ 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 enrollee's health care needs):

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

☒ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

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

Please describe the reasons for which enrollees can request reassignment

The ICO may initiate special disenrollment requests for behaviors as defined in 42 CFR 438.56.

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

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

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

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:

Voluntary enrollment is effective the 1st day of the month after initial receipt of request to enroll, or the 1st day of the month following the month in which the beneficiary is eligible. MDHHS will conduct ongoing Passive enrollment which is effective no sooner than 60 days after beneficiary notification of the right to select an ICO. Effective 7/1/16 MDHHS implemented a new deeming process. In many cases, loss of MA is only temporary due to delays in MA redetermination paperwork or processing. Even though it appears that these individuals have lost MA according to state systems they will be "deemed" eligible for MHL & remain enrolled in the ICO during a deeming period. This period will last up to 3 months after loss of full MA, or until the individual regains full MA, whichever is sooner. ICOs are required to provide MHL covered services to individuals during this time. Additionally, individuals who are determined to have lesser MA (ALMB, SLMB, QMB, or spenddown) will remain enrolled with the ICO for up to 3 months after the full MA end date or until they regain full MA, whichever is sooner. If after the deeming period the individual does not regain full MA, they will be disenrolled from the ICO the last day of the deeming period. MHL will transition to a HIDE SNP program effective 1/1/26. MDHHS conducted a procurement for health plans for the HIDE SNP model. Each ICO operating in the MI Health Link Program has been procured to operate as a HIDE SNP in their current geographic service areas effective 1/1/2026. MDHHS will work with CMS to ensure passive transfer of the plan enrollment and MDHHS will transfer the HCBS enrollment of all MHL beneficiaries to the same health plan's HIDE SNP plan. This approach will be seamless for the beneficiary and promote stability in services and continuity of care. MDHHS will implement a member communication plan to ensure enrollees are provided with applicable information about the program and enrollment transition.

Additionally, MDHHS plans to stop passive enrollment as follows ahead of the program transition:
Oct 24: Submit a change to the passive logic so that we are not passively enrolling people from procured plans into ICOs. This will be effective for all passive pulls, & effective dates, in 2025. This change will be effective for passive pull logic beginning 1/1/25.
Nov 24: Pull the passives that will be effective February 2025, under CURRENT logic.
Dec 24: Pull the passives that will be effective March 2025, under CURRENT logic.
Jan 25: Enrollments are effective from October 2024 passive pull, pulled with current logic. Passive enrollment logic has been updated, so we will no longer pull any beneficiaries from a procured plan, that is not already in ICO. This passive pull enrollment effective date is April 2025.
Feb 25: Enrollments are effective from November 2024 passive pull, pulled with current logic. February 2025 passive pull, with an effective date of May 2025, will be with updated logic.
March 25: Enrollments are effective from December 2024 passive pull, pulled with current logic. March 2025 passive pull, with an effective date of June 2025, will be with updated logic. This will be the last passive pull, with the enrollment effective June 2025.
April 25: Enrollments are effective from January passive pull, pulled with updated logic. There will be no passive pull this month.
May 25: Enrollments are effective from February passive pull, pulled with updated logic. There will be no passive pull this month.
June 25: Enrollments are effective from March passive pull, pulled with updated logic. There will be no passive pull this month. This is the last month that passive enrollments are effective.
July 25 through September 25: Continue to clean up all MHL cases and begin the plan of transitioning. Continue to allow voluntary enrollments for any current ICO plans who are also procured as a HIDE DSNP. Discontinue voluntary enrollments as of 7/1 for any current ICO plans who are NOT procured as a HIDE DSNP.
Oct 25: Medicare/HIDE SNP marketing and voluntary and open enrollment for all Phase 1 procured HIDE SNPs for 1/1/26 effective date.
Oct 25 through Dec 25: Continue to clean up MHL cases and start the transition process (with nothing being effective until 1/1/26). No voluntary enrollments into MHL.
Jan 26: DNSP enrollments are effective.

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:

The grievance and appeal process must follow the process described in the Three-Way Contract and MOU, which include the Medicare and Medicaid processes.

☒ 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 State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 90 days (between 20 and 90).

☐ The State's timeframe within which an enrollee must file a **grievance** is _____ days.

c. Special Needs

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

Please describe:

ICOs are required to provide enrollees with additional assistance for completing forms and working through various procedural steps. Additional assistance includes, but is not limited to, interpreter services and toll-free call centers that have TTY/TDD and interpreter capability.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

Medicaid covered services.

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

☐ the State

☐ the State's contractor.

Please identify:

☐ the PCCM

☐ the PAHP

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

Please describe:

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

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

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

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

☐ Has time frames for resolving requests for review.

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

☐ Establishes and maintains an expedited review process.

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

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

For appeals involving Medicare and Medicaid overlapping benefits, enrollees may file an appeal through either the Medicare or Medicaid appeals processes or both.
Beginning January 1, 2018 all appeals for Medicaid service denials must be made to the ICO prior to filing an appeal with the Michigan Office of Administrative Hearings and Rules (MOAHR).
If an appeal involves an ICO Medicaid only benefit and the enrollee chooses to appeal through the Michigan Department of Financial and Insurance Services (DIFS), Patient Right to Independent Review Act, external review, the enrollee must first exhaust the ICO appeal process.
Initial appeals for Medicare service denials, reductions and terminations will be made to the ICOs; sustained decisions will be auto-forwarded to the Medicare Independent Review Entity (IRE). Enrollees will be able to request a hearing before an Office of Medicare Hearings and Appeals (OMHA) administrative law judge for decisions sustained by the IRE.
The Medicaid Fair Hearing process:
Requests for State Fair Hearing filed on or after January 1, 2018 must be filed within one hundred and twenty (120) days of the notice of resolution following the ICO internal appeal process.
Enrollees have the right to a Fair Hearing when they are denied eligibility (for the MI Health Link §1915(b)/(c) waiver only, the MI Health Link 1915(b) waiver, or Medicaid in general), denied choice of providers, or when services have been denied, suspended, reduced or terminated and the decision was sustained by the ICO during the internal appeal. When denials, suspensions, reductions, or terminations occur, ICOs will provide the enrollee with a notice of denial of medical coverage. This notice of denial of medical coverage is a single, integrated form for Appeals related to Medicare and Medicaid supports and services or providers and must include the following components:
• The action the ICO has taken or intends to take;
• The reasons for the action explained in terms that are easy for the enrollee to understand;
• The citation to the supporting regulations;
• The enrollee's, provider's or authorized representative's right to file an internal Appeal with the ICO and that exhaustion of the ICO's internal Appeal processes is a prerequisite to filing an External Appeal to Medicare for a Medicare service or filing an external review (Patient's Right to Independent Review Act (PRIRA)) with DIFS or the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Medicaid service;
• Procedures for exercising enrollee's rights to appeal;
• The enrollee's right to request a State Fair Hearing in accordance with MCL 400.9,
• Circumstances under which expedited resolution is available and how to request it;
• The enrollee's right to request an independent review of a Medicaid service with the DIFS in the implementation of PRIRA, MCL 550.1901-1929; and
• If applicable, the enrollee's rights to have benefits continue pending the resolution of the appeal, and the circumstances under which the enrollee may be required to pay the costs of these services.

Internal or Initial Appeals for Medicaid service denials will be made to the ICO. If the ICO's decision is sustained in the Initial Appeal, the enrollee may appeal to MOAHR as long as it is within the 120 days of the notice of denial of medical coverage. All Appeals must be resolved by the ICO as expeditiously as the enrollee's condition requires, but always within 30 calendar days of the request for standard appeals, and within 72 hours of the request for expedited appeals. This timeframe may be extended up to 14 days if the party or parties can show there is a need for the delay and it is in the enrollee's best interest. MOAHR will resolve appeals as expeditiously as the enrollee's condition requires, but ordinarily within 90 calendar days of the received request.
The ICO must continue to provide benefits for all prior approved benefits (excluding Medicare Part D) that are terminated or changed pending ICO Internal Appeals. For all appeals filed with MOAHR, ICOs must continue to cover benefits for requests received within 10 calendar days of the notice of denial of medical coverage. In circumstances where the time for a standard appeal is too long and may seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, the ICO or the enrollee's provider may request an Expedited Appeal. If the Expedited Appeal is denied, the appeal request is moved to the standard appeal timeframe and attempts must be made to notify the enrollee immediately and also provide the enrollee with written notice of the denial within two calendar days.
All appeal decisions must be in writing and must include, but not be limited to, the decision that was reached and the date of the decision. If the appeal decision is not entirely in favor of the enrollee, the following information must be included in the notification to the enrollee: 1) the right to request a State Fair Hearing and how to do so within the 120 calendar days timeframe, 2) the right to receive benefits if the Internal Appeal was received within 10 calendar days of the notice of denial of medical coverage, and 3) the right to request external review through PRIRA, DIFS, and how to do so.
Payments for services covered during a pending appeal will not be recouped based on the outcome of the appeal.
Additionally, the Enrollee Handbook (or Member Handbook, the alternative name) which is provided to enrollees upon enrollment will also describe the entire appeals process including the State Fair Hearing process.
Refer to the Three-Way Contract for additional details regarding appeals and grievances processes.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☒ 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	☐ 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
Enrollee Hotlines	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☐ PIHP ☐ PAHP ☐ 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

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

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

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO	☒ 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
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Other	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

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 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	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP

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

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 Health Link	MCO;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: MI Health Link

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

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

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

According to the Three-Way Contract, the ICO is required to submit an annual Adult Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) conducted by a certified vendor. Additionally, MDHHS also contracts with a vendor to complete an annual CAHPS survey across all ICOs.

The CAHPS is used to assess enrollee satisfaction with their healthcare experience. The CAHPS results are utilized in the scoring methodology for quality withhold and passive enrollment algorithm. The aggregate CAHPS results provide important program information as part of the State's overall quality improvement strategy.

Annual waiver audits are conducted utilizing beneficiary interviews to gauge satisfaction and ensuring that members are receiving services they are assessed for on their care plan. Results from telephonic interviews are incorporated into audit findings.

The State may also develop additional survey(s) to capture data for any CMS/State defined performance measures or other initiatives for which there are no related CAHPS measures as indicated in the MI Health Link Quality Strategy. There may also be consumer self-report data related to the concurrent MI Health Link HCBS waiver.

☒ **CAHPS**

Please identify which one(s):

Most current version of the Medicare CAHPS survey completed by each individual ICO. MDHHS contracts with EQRO to conduct HCBS CAHPS Survey across all ICOs.

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

The State reviews available reports and data sources to evaluate enrollment and disenrollment trends, program integrity issues, coverage and authorizations, grievances and appeal activity within the plans, and other measures established by the CMT.

The State reviews provider files to evaluate PCP/Specialist Capacity and access by plan. The CMT monitors the overall number and rate of PCP's that either voluntarily leave or are terminated from the ICOs provider network through review of the annual PCP Turnover Report.

MDHHS also conducts data analysis for the MI Health Link HCBS waiver Quality Improvement Strategy. There are many performance measures in the Quality Improvement Strategy that require analysis of data from many sources such as annual on-site and off-site reviews of ICOs, home visits/interviews with enrollees, the MMIS system (CHAMPS), the Waiver Management System for MI Health Link HCBS, provider monitoring reports, and the Critical Incident Management System.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

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

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

Provider Files

e. ☒ **Enrollee Hotlines**

Activity Details:

The State maintains a beneficiary Michigan ENROLLS telephone line to address enrollee inquiries regarding provider choice, enrollment/disenrollment, and other related questions and concerns.

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

Activity Details:

g. ☒ **Geographic mapping**

Activity Details:

MDHHS requires geographic mapping as part of the contract requirements for adequate provider networks and for changes in service area. Geographic mapping is monitored by the State during annual provider network validation. The ICO must have at least two available providers for each provider type with sufficient capacity to accept enrollees. For services provided in the enrollee's home, the ICO must assure that the enrollee has choice of providers. For services provided in the community, the ICO must assure that the enrollee has a choice of providers and the enrollee does not travel more than 30 miles or for more than 30 minutes to receive the service. (Travel time is measured during non-peak hours.) If the ICO cannot assure choice within the travel time or distance for each Enrollee, it may make a request of MDHHS for a rural exception.

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

Activity Details:

The independent assessment for MI Health Link will be conducted by a contractor selected by MDHHS. Contractor will complete the independent assessments according to CMS issued guidelines.

This report reflects a comprehensive review and synthesis of the available data and reports generated from evaluation activities available through CMS and the State of Michigan for the MHL Program. The assessment activities are broadly organized under four overarching domains: Access to Care, Quality of Care, Cost Effectiveness, and Program Management and Operations. Each measure identified in the original CMS/MDHHS MOU were categorized into one of these overarching domains for organizational purposes within this assessment report. The conclusions provided herein summarize findings derived from a variety of sources including administratively-based utilization data/health care records as well as MHL Program stakeholder (e.g., enrollee, provider, ICO, PIHP and MDHHS staff) feedback.

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

Activity Details:

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

Activity Details:

The network adequacy data provides evaluation of and information for provider capacity, provider selection and enrollee choice.
Network Validation is completed annually in the fall.

k. ☒ **Ombudsman**

Activity Details:

Through the State's procurement process, the Michigan Advocacy Program was selected to contract with MDHHS to implement the MI Health Link Ombudsman (MHLO) program. MDHHS has direct oversight of the MHLO. MDHHS will ensure all required reporting (ad hoc, quarterly, and semi-annually) is completed and forwarded to CMS, when appropriate.

l. ☒ **On-Site Review**

Activity Details:

MDHHS contracts with an EQRO to conduct compliance reviews to ensure ICO compliance with contract requirements for choice, program integrity, information to beneficiaries, grievances, timely access, PCP/Specialists capacity, coordination/continuity of care, coverage/authorization, provider selection, and quality of care. Compliance review reports are developed which provide a summary of findings, identification of areas in which action is needed, and opportunities for improvement.

CMT members will conduct on-site visits as needed to evaluate and monitor program activities.

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

Activity Details:

ICOs are required to conduct Performance Improvement Projects (PIP). Generally, ICOs can select PIP topics specific to the populations within each ICO. However, the State may also identify and mandate topics for specific regional or program-wide projects. HSAG is acting as the state's EQRO and the state has defined the topic of Health Disparity for the current PIP; This PIP or QIP (Quality Improvement Project) was chosen to align with one of the goals within the MDHHS Comprehensive Quality Strategy: MDHHS Comprehensive Quality Strategy Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes. Objective A: Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source when possible. Objective D: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations. MDHHS did not mandate a statewide topic for this focus but rather allowed the ICOs to identify existing racial or ethnic disparities within the region(s) and populations served and determine its plan-specific topic and performance indicator(s). The ICOs could utilize national specifications (HEDIS), CMS Core or Michigan specific measures, or develop a home-grown measure as appropriate for the region(s) and populations served. CY 22 was year 1 of the PIP 3 year cycle. HSAG performed validation of the ICO's improvement projects. We are currently in year 3 of this cycle with remeasurement and evaluation/validation of statistically significant improvement in health disparity for chosen disparity gaps for each ICO. CY24 is year 3 of the PIP cycle. It was determined that HSAG will continue into year 4 in 2025 with this healthy disparity PIP with remeasurement and evaluation/validation of statistically significant improvement in health disparity for the chosen disparity gaps for each ICO.

☒ **Clinical**

☒ **Non-clinical**

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

Activity Details:

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

The State has also identified key HEDIS and AHRQ/CAHPS measures for tracking and trending. Additionally, the EQRO will evaluate areas of opportunity and provide recommendations in the final EQR Technical Report. The Technical Report is available annually at the end of April. The report is publicly posted to the MHL website and shared with ICOs along with any recommendations from the EQRO activities performed throughout the year. Each fall the ICOs are expected to provide responses to the recommendations in the report with strategies and plans to address these recommendations to make improvements to program deficiencies. The MHL CMT works closely with the EQRO and will take actions on recommendations as available.

These data provide information relative to grievances, timely access, and quality of care. MDHHS utilizes these data in setting quality strategy goals, performance standards, improvement plans, passive enrollment assignments, and payment related to quality withhold.

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

☒ **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:

Weekly provider files for PCPs and Specialists are collected and monitored and an annual network validation is conducted for each ICOs full network of providers. The CMT monitors the overall number and rate of PCP's that either voluntarily leave or are terminated from the ICOs provider network through review of the annual PCP Turnover Report.

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

Activity Details:

q. ☒ **Provider Self-Report Data**

Activity Details:

The annual compliance review, conducted by HSAG, includes review of ICO Grievance and Appeals systems. The HSAG compliance review also monitors ICO's Quality Improvement and Performance Improvement Plan (QAPI) which requires ICOs maintain adequate access to and availability of primary care, behavioral health care, pharmacy, specialty health care, and LTSS providers and services. In addition, the State reviews provider self-reported data on Grievances through collection of the annual Managed Care Program Annual Report (MCPAR) Workbook. As stated above, the State reviews provider files to evaluate PCP/Specialist Capacity and access by plan. The CMT monitors the number and rate of PCP's that either voluntarily leave or are terminated from the ICOs provider network through review of the annual PCP Turnover Report.

☐ **Survey of providers**

☐ **Focus groups**

r. ☒ **Test 24/7 PCP Availability**

Activity Details:

The State requires ICOs to monitor 24/7 Primary Care Provider availability and the requirement that each location must be open a minimum of 20 hours per week. This is reviewed by State staff through the CMT. The annual compliance review, conducted by HSAG, monitors ICO's Quality Improvement and Performance Improvement Plan (QAPI) which requires ICOs maintain adequate access to and availability of primary care providers. The CMT works closely with HSAG through the compliance review.

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

Activity Details:

ICOs conduct utilization reviews. The State assures that the ICO has a utilization management program that governs the ICO's utilization review and decision-making through the CMT. The annual compliance review, conducted by HSAG, includes review of the Utilization Management Program that governs the ICO's utilization review and decision-making. The CMT works closely with HSAG through the compliance review.

t. ☒ **Other**

Activity Details:

The State staff routinely conducts review of marketing, educational and member material to ensure contract compliance prior to distribution by the ICO. The Three-Way Contract defines the criteria for marketing materials. The CMT is utilized as a vehicle to request additional data as needed from ICOs and conduct routine and ad hoc monitoring through monthly calls and as needed on-site visits. HSAG conducted a 3 year compliance review cycle 2022-2024. With review of all outstanding CAPs and deficiencies addressed with those plans. In 2022 a new QIP was identified and 3 year QIP cycle started for health disparity; however, this has been expanded to a fourth year of validation in 2025. The technical report is available annually in April and recommendations are addressed by ICOs in writing in the fall of each year.

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

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

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

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

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Consumer Self-Report data: Both ICOs&MDHHS conducted annual surveys to gather feedback on enrollee experience. Results were reviewed with individual ICOs through the monthly CMT meeting. Areas of opportunity that ICOs needed to address were identified as were areas of success. Results of the MDHHS annual CAHPS survey are posted publicly on the MI Health Link website.

State developed survey: MDHHS contracted with the Institute for Health Policy to conduct surveys of individuals that were enrolled, never enrolled, and disenrolled from MI Health Link. Results were aggregated analyzed by MDHHS and shared with ICOs to help drive improvements and develop mechanisms to address the reasons identified for disenrollment.

Data Analysis: Provider Files have been monitored throughout the demonstration w/ no issues identified. All of the ICOs have adequate networks to address enrollee needs. Types of grievances & appeals have also been monitored & as needed discussed w/ the ICOs to ensure systematic changes were made as needed. A detailed review of multiple data sources including enrollee interview, record & system review has been completed annually as part of the waiver quality assurance process. These reviews result in an annual report for each ICO & where needed corrective action plans were developed and monitored by MDHHS until compliance was achieved. Results have also been included in the CMS-372 report.

Enrollee Hotline: The State maintains a beneficiary Michigan ENROLLS telephone line to address enrollee inquiries regarding provider choice, enrollment/disenrollment, & other related questions & concerns. No significant issues or trends were identified through this means.

Geographic Mapping/Network Adequacy/Periodic Comparison of # of Providers: All ICO networks were deemed compliant through this process or exceptions were approved.

Independent Assessment: MDHHS contracted with the Institute for Health Policy to complete an assessment of the demonstration’s impact on the quality, access and cost of care. That report is submitted along with this application for renewal.

Ombudsman: MDHHS monitored all MI Health Link Ombudsman reporting for patterns/trends and discussed with both the Ombudsman, and CMS and the ICOs through the CMT. Monthly calls were held with the Ombudsman to work through any identified issues.

On-Site Review: While much of the oversight and monitoring through the CMT was off-site each team met on-site at the ICO throughout the demonstration as well. On-site waiver audits were completed during the demonstration to evaluate ICO compliance with performance measures and ensure waiver services were being administered according to regulation and guidance.

Other: State staff routinely conducts review of marketing, educational and member materials to ensure compliance with contractual requirements. No significant findings/patterns were identified.

EQRO Activities: Based on the recommendations of the EQRO MDHHS has initiated a review of a sample of each ICOs IICSPs. The review is focusing on the person centeredness and inclusion of required elements and spans a 4 month period with discussions held during the monthly CMT call to discuss findings. The CMT discussed plan denials on as a monthly topic with ICOs including denial templates, use of denials/vendors using appropriate templates. MDHHS will develop and require plans to submit a denial file quarterly. A sample will be audited for compliance. MDHHS is planning to hold an educational opportunity jointly with the MHLO for plans related to Denials/Appeals and Grievances. MDHHS has implemented a provider monitoring program with plans completing monitoring of direct waiver service providers and submitting their monitoring reports to MDHHS for review and tracking. HSAG will also conduct a focused review of appeals and grievances as an EQR function. MDHHS will collect and review ICOs QAPI plans.

Performance Improvement Projects: ICOs maintain Quality Improvement Plans that were monitored through the EQR process. Additionally, MDHHS and CMS collected data from ICOs related to mandatory Quality and Performance Improvement Projects with topics defined by CMS and/or the State throughout the demonstration. Results of Quality Projects are discussed with all ICOs through Quality Workgroup Meetings and MHL Quality data is shared with enrollees through State Advisory Council Meetings.

Performance Measures: The State and CMS have defined Performance Measures that were monitored routinely throughout the demonstration. The CMT, and waiver quality assurance audits were vehicles used to monitor all measures which covered quality of care, access to care, customer service, encounter data, care coordination, and claims reporting and processing. Areas of opportunity are discussed with ICOs and corrective action plans are required when applicable. Data is reported through the CMS 372 report and also utilized when designing quality strategy goals, performance standards, payments related to quality withholds,

and passive enrollment assignments. Best practices are discussed through Quality Management Workgroup Meetings and Quality Data is shared with enrollees through State Advisory Council Meetings.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Community Residents	
Nursing Facility Level of Care - Waiver	
Nursing Facility	

	First Period		Second Period	
	Start Date	**End Date**	**Start Date**	**End Date**
Actual Enrollment for the Time Period**	01/01/2023	12/31/2023	01/01/2024	06/30/2024
Enrollment Projections for the Time Period*	01/01/2025	12/31/2025	01/01/2026	12/31/2026

**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	
Physician Services	☒	☐	☒	
Outpatient Hospital (excludes psych)	☒	☐	☒	
Chore Services (1915c waiver)	☐	☐	☒	
Adaptive Medical Equipment and Supplies (1915c waiver)	☐	☐	☒	
Environmental Modifications (1915c waiver)	☐	☐	☒	
Certified Nurse Anesthetist	☒	☐	☒	
Personal Emergency Response System (1915c waiver)	☐	☐	☒	
Inpatient Hospital (excludes psych)	☒	☐	☒	
Laboratory and Radiology	☒	☐	☒	
Oral Surgeons	☒	☐	☒	
Other DME & Medical Supplies	☒	☐	☒	
Expanded Community Living Supports (1915c waiver)	☐	☐	☒	
Rural Health Clinic	☒	☐	☒	
Non-Skilled Nursing Home Stay (Leave Days)	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Home Health - Oxygen, DME, & Medical Supplies	☒	☐	☒	
Medicaid Covered Drugs (includes over the counter)	☒	☐	☒	
Chiropractors	☒	☐	☒	
Skilled Nursing Home - Maintenance and Co-Insurance Days	☒	☐	☒	
Fiscal Intermediary (1915c waiver)	☐	☐	☒	
Tribal 6.38	☒	☐	☒	
Community Transition Services (1915i effective 4/24/19)	☒	☐	☒	
Preventive Nursing Services (1915c waiver)	☐	☐	☒	
Private Duty Nursing (1915c waiver)	☐	☐	☒	
Individual Directed Goods and Services (1915c waiver)	☐	☐	☒	
Home Delivered Meals (1915c waiver)	☐	☐	☒	
Clinic Services	☒	☐	☒	
Nurse Midwives	☒	☐	☒	
Home Health - Intermittent or Part-Time Nursing Services	☒	☐	☒	
Optometrist	☒	☐	☒	
Respiratory Care	☒	☐	☒	
Non-Medical Transportation (1915c waiver)	☐	☐	☒	
FQHC	☒	☐	☒	
Vision Services and Eyeglasses	☒	☐	☒	
Respite (1915c waiver)	☐	☐	☒	
Podiatrist	☒	☐	☒	
Sterilizations	☒	☐	☒	
Prosthetics and Orthotics	☒	☐	☒	
Assistive Technology (1915c waiver)	☐	☐	☒	
Speech and Hearing Services	☒	☐	☒	
Adult Day Program (1915c waiver)	☐	☐	☒	
Personal Care Services	☒	☐	☒	
Family Planning	☒	☐	☒	
Vehicle Modifications (1915c waiver)	☐	☐	☒	
Hearing Aids	☒	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature:	Meghan Groen
	State Medicaid Director or Designee
Submission Date:	Aug 26, 2025

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

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

b. Name of Medicaid Financial Officer making these assurances:

Brian Keisling

c. Telephone Number:

(517) 241-7181

d. E-mail:

KeislingB@michigan.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

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

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

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

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

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

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☒ **MCO**

b. ☐ **PIHP**

c. ☐ **PAHP**

d. ☐ **PCCM**

e. ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

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

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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

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

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

We have reported actual enrollment for the base period of January 1, 2023 through June 30, 2024. Projected quarterly enrollment has been estimated assuming 1% annual growth from quarter two of CY 2024 through quarter three of CY 2027. We have maintained the enrollment for the remainder of the 5-year waiver period.

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

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

The BY is CY 2023 and CY 2024 Jan-June.

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:

- ☒ **[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:

Vehicle Modifications was added as a 1915c waiver service.

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

Hospice services have been excluded from the cost-effectiveness analysis due to individuals receiving hospice being excluded from the MI Health Link program.

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
Physician Services	☒	☐	☐	☐	☐	☐	☐
Outpatient Hospital (excludes psych)	☒	☐	☐	☐	☐	☐	☐
Chore Services (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Adaptive Medical Equipment and Supplies (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Environmental Modifications (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Certified Nurse Anesthetist	☒	☐	☐	☐	☐	☐	☐
Personal Emergency Response System (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Inpatient Hospital (excludes psych)	☒	☐	☐	☐	☐	☐	☐
Laboratory and Radiology	☒	☐	☐	☐	☐	☐	☐
Oral Surgeons	☒	☐	☐	☐	☐	☐	☐
Other DME & Medical Supplies	☒	☐	☐	☐	☐	☐	☐
Expanded Community Living Supports (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Rural Health Clinic	☒	☐	☐	☐	☐	☐	☐
Non-Skilled Nursing Home Stay (Leave Days)	☒	☐	☐	☐	☐	☐	☐

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
Home Health - Oxygen, DME, & Medical Supplies	☒	☐	☐	☐	☐	☐	☐
Medicaid Covered Drugs (includes over the counter)	☒	☐	☐	☐	☐	☐	☐
Chiropractors	☒	☐	☐	☐	☐	☐	☐
Skilled Nursing Home - Maintenance and Co-Insurance Days	☒	☐	☐	☐	☐	☐	☐
Fiscal Intermediary (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Tribal 6.38	☒	☐	☐	☐	☐	☐	☐
Community Transition Services (1915i effective 4/24/19)	☒	☐	☐	☐	☐	☐	☐
Preventive Nursing Services (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Private Duty Nursing (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Individual Directed Goods and Services (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Home Delivered Meals (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Clinic Services	☒	☐	☐	☐	☐	☐	☐
Nurse Midwives	☒	☐	☐	☐	☐	☐	☐
Home Health - Intermittent or Part-Time Nursing Services	☒	☐	☐	☐	☐	☐	☐
Optometrist	☒	☐	☐	☐	☐	☐	☐
Respiratory Care	☒	☐	☐	☐	☐	☐	☐
Non-Medical Transportation (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
FQHC	☒	☐	☐	☐	☐	☐	☐
Vision Services and Eyeglasses	☒	☐	☐	☐	☐	☐	☐
Respite (1915c waiver)	☒	☐	☐	☐	☐	☐	☐

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
Podiatrist	☒	☐	☐	☐	☐	☐	☐
Sterilizations	☒	☐	☐	☐	☐	☐	☐
Prosthetics and Orthotics	☒	☐	☐	☐	☐	☐	☐
Assistive Technology (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Speech and Hearing Services	☒	☐	☐	☐	☐	☐	☐
Adult Day Program (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Personal Care Services	☒	☐	☐	☐	☐	☐	☐
Family Planning	☒	☐	☐	☐	☐	☐	☐
Vehicle Modifications (1915c waiver)	☒	☐	☐	☐	☐	☐	☐
Hearing Aids	☐	☐	☐	☐	☐	☐	☐

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:

We have developed the state administrative costs based on the filed PMPMs for Projection Year 5 from the prior 5-year waiver submission. Because this level of information is not readily available, we used the information provided by MDHHS for the previous submission to determine the administrative allocation by line item and per member per month cost for each of the three MEGs. Using actual enrollment for the base period of January 1, 2023 through June 30, 2024, we estimated the emerging administrative costs for the base period.

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:

The MI Health Link capitation rates are developed utilizing actual experience for the MI Health Link program and represents experience only for those members that opt to remain in the program.

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

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

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

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

   Document

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

i. MDHHS will be withholding a percentage of the capitation payments and will pay this out to ICOs after the end of the year based on their performance indicators. The criteria for the awards are communicated to the ICOs each year. The withhold for CY 2025 is 4%.

ii. For each contract year, performance bonus incentives are withheld from the capitation payments for the respective ICOs. 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 included as part of the capitated costs in the Appendix D spreadsheets for the purposes of determining cost effectiveness.

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

Document:

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

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

1. ☐ **[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is:

   Please document how that trend was calculated:

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

   i. ☒ **State historical cost increases.**

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

   The retrospective year information reflected in the Appendix D workbook encompasses 18 months of incurred experience that was paid to the integrated care organizations as the Medicaid rate component of the demonstration program. The 18-month base period extends from January 1, 2023 through June 30, 2024.We have included inflationary estimates in Column L for state plan services and Column AA for 1915(c) waiver services reflect estimated capitation rates for the MI Health Link program. These adjustments reflect the changes being applied to the historical costs reported on tab D3. Actual Waiver Cost, to reflect potential
   increases in future years.

   ii. ☐ **National or regional factors that are predictive of this waiver's future costs.**

   Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**

   Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

   i. Please indicate the years on which the utilization rate was based (if calculated separately only).

   ii. Please document how the utilization did not duplicate separate cost increase trends.

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

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

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates,

changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

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

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

Increases have been reflected in Column N and AC to account for capitation rate changes effective for CY 2025. The percentages vary by MEG w/ 5% for Nursing Facility, 18% for NFLOC-Waiver and 20% for Community Residents. These increases represent significant changes from the prior year capitation rates due to utilization and cost changes in emerging experience from the participating MCOs.

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

Increases have been reflected in Column N and AC to account for capitation rate changes effective for CY 2025. The percentages vary by MEG w/ 5% for Nursing Facility, 18% for NFLOC-Waiver and 20% for Community Residents. These increases represent significant changes from the prior year capitation rates due to utilization and cost changes in emerging experience from the participating MCOs.

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:

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

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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 isPMPM size of adjustment

3.00

Please describe:

The trend for administration is based on the Consumer Price Index and experience with the cost of in-house staff dedicated to managed care functions.

D. ☐ Other

Please describe:

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

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

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

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

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

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

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

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

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

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

   B. State Plan Service trend

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

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

1. List the State Plan trend rate by MEG from Section D.I.I.a
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
3. Explain any differences:

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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 State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost

effectiveness process.

- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

  Basis and Method:

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

     Please describe:

1. ☒ No adjustment was made.

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

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K. Appendix D5 – Waiver Cost Projection

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

The retrospective year information reflected in the Appendix D workbook encompasses 18 months of incurred experience that was paid to the integrated care organizations as the Medicaid rate component of the demonstration program. The 18-month base period extends from January 1, 2023 through June 30, 2024. We have included inflationary estimates in Column L for state plan services and Column AA for 1915(c) waiver services reflect estimated capitation rates for the MI Health Link program. These adjustments reflect the changes being applied to the historical costs reported on tab D3. Actual Waiver Cost, to reflect potential increases in future years. Increases have been reflected in Column N and Column AC to account for capitation rate changes that were effective for CY 2025. These percentages vary by MEG with 5% for Nursing Facility, 18% for NFLOC-Waiver and 20% for Community Residents. These increases represent significant changes from the prior year capitation rates due to utilization and cost changes in emerging experience from the participating managed care organizations. None of these changes are due to any SPA modifications.

Appendix D5 – Waiver Cost Projection

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L. Appendix D6 – RO Targets

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

Appropriate changes made on the D5 Waiver Cost Projection section flowed through to this section.

Appendix D6 – RO Targets

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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. Previously filed Appendix D values for the CY 2023 and first half of CY 2024 periods are included in applicable columns K-P.

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 State's 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 State's 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.

Increases have been reflected in Column N and Column AC to account for capitation rate changes that were effective for CY 2025. These percentages vary by MEG with 5% for Nursing Facility, 18% for NFLOC-Waiver and 20% for Community Residents. These increases represent significant changes from the prior year capitation rates due to utilization and cost changes in emerging experience from the participating managed care organizations. None of these changes are due to any SPA modifications.

Appendix D7 - Summary