



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

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DIRECTOR

January 21, 2011

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

Dear Ms. Johnson:

Enclosed is Michigan's application for a two-year renewal of the Healthy Kids Dental Waiver Program authorized under Sections 1915(b) (4) of the Social Security Act.

Michigan Department of Community Health staff stands ready to quickly respond to any questions or concerns CMS staff may have. We continue to appreciate the consultation of staff in CMS central, regional and Lansing offices in meeting waiver requirements.

If you have any questions or need additional information, please contact Cheryl Bupp (517) 241-7933 or at buppc@michigan.gov.

Sincerely,

A handwritten signature in black ink that reads "Stephen Fitton".

Stephen Fitton, Director
Medical Services Administration

Enclosure

cc: Leslie N. Campbell
MaryAnn McGuire
Catherine Song
Mara Siler-Price
Susan Moran
Cheryl Bupp
Jacqueline Coleman

**Section 1915(b) Waiver Proposal For:
Michigan's Healthy Kids Dental Waiver**

**MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs**

January 21, 2011

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Instructions – see Attachment 1

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

Facesheet

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

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

The **name of the waiver program** is Healthy Kids Dental. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part _____
 - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
 - Document is replaced in full, with changes highlighted
- renewal request
 - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
 - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
 - Section A is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
 - Section B is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Monitoring Plan from the previous waiver period.
 - assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective 04/01/2011 and ending 03/31/2013.

State Contact: The State contact person for this waiver is Cheryl Bupp and can be reached by telephone at (517) 241-7933, or fax at (517) 241-5713, or e-mail at buppc@michigan.gov.

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.

The quarterly Tribal Health Directors meeting offers Tribal chairs and the health directors an opportunity to be updated on the activities, operations, and changes of the Medicaid Managed Care Program.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

In 1997–98, the Michigan Department of Community Health (MDCH), which administers Michigan’s Medicaid and MICHild programs convened a Task Force to evaluate long standing problems in Medicaid’s dental program. The Task Force proposed budgetary increases, new administrative options, and a new delivery system. With political support from a broad array of stakeholders, primarily the Michigan Primary Care Association, University of Michigan Dental School and Michigan Dental Association, the state legislature appropriated \$10.9 million for FY 2000 to expand access to oral health services for Medicaid beneficiaries, focusing on rural areas. Approximately half the appropriation was used to create a new Medicaid managed care dental service delivery model, called *Healthy Kids Dental (HKD)*.

Healthy Kids Dental functions similar to commercial dental insurance. In establishing HKD as a demonstration within specific counties, the MDCH contracted with a dental insurance carrier, Delta Dental Plan of Michigan—a nonprofit service corporation that administers group dental benefits for more than 3 million people—to administer the Medicaid dental benefit in accordance with its own standard procedures, claim form, and payment levels and mechanisms. HKD enrollees receive a member identification card that looks very similar to that given to commercial enrollees and may use any Delta network dentist. In May 2000, the state converted the traditional dental coverage of all Medicaid-enrolled children in 22 of Michigan’s 83 counties to HKD.

Since the inception of the program, Michigan has expanded the service area covered by the HKD program on several occasions.

- **October 2000 - expanded to 15 more counties (total number of counties served by HKD increased to 37)**
- **May 2006 – expanded to 22 more counties (total number of counties served by HKD increased to 59)**

- **July 2008 – expanded to 2 urban counties(total number of counties served by HKD increased to 61)**

In 2009, Healthy Kids Dental contract was included in the Contracts Management module of new Medicaid Management Information System (CHAMPS). This facilitates tracking the number of children with both commercial and Healthy Kids Dental insurance. In 2010, the submission and monitoring of encounter data was also incorporated into CHAMPS. This enables the Department to produce regular and ad hoc reports on the types and number of dental services provided to Medicaid beneficiaries.

In 2010, administration of the Healthy Kids Dental waiver program transferred to the Managed Care Plan Division to allow Michigan to take advantage of economies of scale in the management of the contract. The transfer also allows Michigan to better monitor the contract by learning from best practices developed through the monitoring of the Medicaid Health Plans.

A. Statutory Authority

1. **Waiver Authority**. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

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

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

- a. **XX** **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

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

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

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

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

B. Delivery Systems

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

a. ___ **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. **XX Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)
Contractor is paid on a per member per month basis and is shared risk subject to cost settlement at the end of the fiscal year.
- f. ___ **Other:** (Please provide a brief narrative description of the model.)

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

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

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

1. Assurances.

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

XX The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

Based on the county of residence, eligible beneficiaries are automatically enrolled with the dental Contractor. State of Michigan has a single dental Contractor that operates with a network of dentists. Beneficiaries are notified that they are part of the dental plan and the Contractor provides a list of participating dentists in the geographical area in which the beneficiary resides. Beneficiaries enrolled in the dental plan with the Contractor receive a member packet that describes the dental plan along with a list of participating dentists within their geographical area. Beneficiaries have freedom of choice from among the participating network of dentists. The Contractor has customer service staff to assist beneficiaries with locating and choosing a dentist.

Currently, the dental plan is operating in 61 of Michigan's 83 counties. (Please see list below in Section D-2).

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

- ___ Two or more MCOs
- ___ Two or more primary care providers within one PCCM system.
- ___ A PCCM or one or more MCOs
- ___ Two or more PIHPs.
- ___ Two or more PAHPs.

XX Other: (please describe) **Two or more dental providers within one Dental Contractor provider network panel.**

3. **Rural Exception.**

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

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

— **XX** Beneficiaries will be limited to a single provider in their service area (please define service area).

Enrollees have choice of two or more dental providers within one Dental Contractor provider network panel.

— Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

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

Less than Statewide

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
ALCONA	Selective Contract	DELTA DENTAL PLAN OF MI
ALGER	Selective Contract	DELTA DENTAL PLAN OF MI
ALLEGAN	Selective Contract	DELTA DENTAL PLAN OF MI
ALPENA	Selective Contract	DELTA DENTAL PLAN OF MI
ANTRIM	Selective Contract	DELTA DENTAL PLAN OF MI
ARENAC	Selective Contract	DELTA DENTAL PLAN OF MI
BARAGA	Selective Contract	DELTA DENTAL PLAN OF MI
BARRY	Selective Contract	DELTA DENTAL PLAN OF MI
BENZIE	Selective Contract	DELTA DENTAL PLAN OF MI
BRANCH	Selective Contract	DELTA DENTAL PLAN OF MI
CHARLEVOIX	Selective Contract	DELTA DENTAL PLAN OF MI
CHEBOYGAN	Selective Contract	DELTA DENTAL PLAN OF MI
CHIPPEWA	Selective Contract	DELTA DENTAL PLAN OF MI
CLARE	Selective Contract	DELTA DENTAL PLAN OF MI
CLINTON	Selective Contract	DELTA DENTAL PLAN OF MI
CRAWFORD	Selective Contract	DELTA DENTAL PLAN OF MI
DELTA	Selective Contract	DELTA DENTAL PLAN OF MI
DICKINSON	Selective Contract	DELTA DENTAL PLAN OF MI
EATON	Selective Contract	DELTA DENTAL PLAN OF MI
EMMET	Selective Contract	DELTA DENTAL PLAN OF MI
GENESEE	Selective Contract	DELTA DENTAL PLAN OF MI
GLADWIN	Selective Contract	DELTA DENTAL PLAN OF MI
GOGEBIC	Selective Contract	DELTA DENTAL PLAN OF MI
GRATIOT	Selective Contract	DELTA DENTAL PLAN OF MI
HILLSDALE	Selective Contract	DELTA DENTAL PLAN OF MI

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
HOUGHTON	Selective Contract	DELTA DENTAL PLAN OF MI
HURON	Selective Contract	DELTA DENTAL PLAN OF MI
IONIA	Selective Contract	DELTA DENTAL PLAN OF MI
IOSCO	Selective Contract	DELTA DENTAL PLAN OF MI
IRON	Selective Contract	DELTA DENTAL PLAN OF MI
ISABELLA	Selective Contract	DELTA DENTAL PLAN OF MI
KALKASKA	Selective Contract	DELTA DENTAL PLAN OF MI
KEWEENAW	Selective Contract	DELTA DENTAL PLAN OF MI
LAKE	Selective Contract	DELTA DENTAL PLAN OF MI
LAPEER	Selective Contract	DELTA DENTAL PLAN OF MI
LEELANAU	Selective Contract	DELTA DENTAL PLAN OF MI
LENAWEE	Selective Contract	DELTA DENTAL PLAN OF MI
LIVINGSTON	Selective Contract	DELTA DENTAL PLAN OF MI
LUCE	Selective Contract	DELTA DENTAL PLAN OF MI
MACKINAC	Selective Contract	DELTA DENTAL PLAN OF MI
MANISTEE	Selective Contract	DELTA DENTAL PLAN OF MI
MARQUETTE	Selective Contract	DELTA DENTAL PLAN OF MI
MENOMINEE	Selective Contract	DELTA DENTAL PLAN OF MI
MIDLAND	Selective Contract	DELTA DENTAL PLAN OF MI
MISSAUKEE	Selective Contract	DELTA DENTAL PLAN OF MI
MONROE	Selective Contract	DELTA DENTAL PLAN OF MI
MONTMORENCY	Selective Contract	DELTA DENTAL PLAN OF MI
OGEMAW	Selective Contract	DELTA DENTAL PLAN OF MI
ONTONAGON	Selective Contract	DELTA DENTAL PLAN OF MI
OSCODA	Selective Contract	DELTA DENTAL PLAN OF MI
OTSEGO	Selective Contract	DELTA DENTAL PLAN OF MI
PRESQUE ISLE	Selective Contract	DELTA DENTAL PLAN OF MI
ROSCOMMON	Selective Contract	DELTA DENTAL PLAN OF MI
SAGINAW	Selective Contract	DELTA DENTAL PLAN OF MI
SAINT CLAIR	Selective Contract	DELTA DENTAL PLAN OF MI
SAINT JOSEPH	Selective Contract	DELTA DENTAL PLAN OF MI
SANILAC	Selective Contract	DELTA DENTAL PLAN OF MI
SCHOOLCRAFT	Selective Contract	DELTA DENTAL PLAN OF MI
SHIAWASSEE	Selective Contract	DELTA DENTAL PLAN OF MI
TUSCOLA	Selective Contract	DELTA DENTAL PLAN OF MI
VAN BUREN	Selective Contract	DELTA DENTAL PLAN OF MI

E. Populations Included in Waiver

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

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

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

(NOTE: Foster care children who reside in a Court Treatment Facility, Mental Health Facility, Detention Center, Child Care Institute, out-of-state foster home, out-of-state facility, or in jail are excluded from enrollment)

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

- Mandatory enrollment**
 Voluntary enrollment

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

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

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/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

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.

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

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

XX **Other** (Please define):

Foster care children who reside in a Court Treatment Facility, Mental Health Facility, Detention Center, Child Care Institute, out-of-state foster home, out-of-state facility, or in jail are excluded from enrollment

F. Services

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

1. Assurances.

- _____ 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.
- XX** 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. **This is a proposal for a 1915(b)(4) waiver under which only dental services are covered.**
- _____ *The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.*

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-

(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

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

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

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

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

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

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

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

___ Other (please explain):

XX Family planning services are not included under the waiver.

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

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

— 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:

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

5. **EPSDT Requirements.**

XX The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

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

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

7. **Self-referrals.**

XX 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:

Emergency Services

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

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

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

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

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

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

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

1. ___ PCPs (please describe):

2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

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

- **Time and distance:** One of the annual measurements for the evaluator is to review the time and distance for travel for the beneficiaries.
- **Waiting times to obtain services:** This will be a measurement in the annual beneficiary survey to determine how long it takes to schedule an appointment.
- **Provider-to-beneficiary ratios:** The State and Contractor has to have a provider-to-beneficiary ratio per county that is at least 20% greater than the current FFS ratio.
- **Beneficiary knowledge of how to appropriately access waiver services:** Review of the newsletters and all materials developed by the Contractor will be conducted by the State prior to the mailings to beneficiaries.
- **Access to emergency services:** The Contractor will be required to provide materials to beneficiaries on the procedure for accessing emergency treatment on a twenty-four (24) hours a day and seven (7) days a week basis.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

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

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

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

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

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

- a. ___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. ___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. ___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.
- d. ___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

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

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

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

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

Area(City/ounty/Region)	PCCM-to-Enrollee Ratio
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

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

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

- **In the previous waiver period, provider-to-beneficiary ratio was approximately 1:650 as compared to 1:1400 prior to the waiver under fee-for-service.**
- **Beneficiaries are not assigned dental providers within the dental plan. They are free to choose among the participating dentists within the dental plan network.**
- **The Dental Plan contractor has approximately X providers while only 4,780 dentists are enrolled in the fee-for-service provider system. Similarly, many of the fee-for-service enrolled dentists limit the number of Medicaid beneficiaries allowed in their practice.**
- **With a larger network of participating providers in the dental network, the State has experienced an increase in utilization of dental services and seen the travel distance of the beneficiaries enrolled in the dental plan decrease.**

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

- ___ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.
- ___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- ___ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

The following items are required.

- a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
- b. ___ **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.
- c. ___ **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
- d. ___ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the

MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. ___ In accord with any applicable State quality assurance and utilization review standards.
- e. ___ **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

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

- a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. ___ Each enrollee is receives **health education/promotion** information. Please explain.
- d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. ___ There is appropriate and confidential **exchange of information** among providers.
- f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

- h. ____ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
 - i. ____ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

The Contractor has a network of participating dentists and the beneficiaries are able to choose a participating dentist of their choice. Providers are only able to request that the beneficiary be reassigned to a new provider if the patient/provider relationship is not mutually acceptable; if the patient's condition or illness would be better treated by another provider type; or if the provider is no longer operating as a Medicaid dental provider in the beneficiary's service area. If the reassignment is approved, the provider must send a certified letter to the beneficiary acknowledging the change of provider relationship. The Dental Contactor is responsible for assisting the beneficiary in locating a new dental provider.

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

_____ 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 _____.

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

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

2. **Assurances For PAHP program.**

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

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

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

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

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

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

1. ___ Provide education and informal mailings to beneficiaries and PCCMs;

2. ___ Initiate telephone and/or mail inquiries and follow-up;

3. ___ Request PCCM's response to identified problems;

4. ___ Refer to program staff for further investigation;

5. ___ Send warning letters to PCCMs;

6. ___ Refer to State's medical staff for investigation;

7. ___ Institute corrective action plans and follow-up;

8. ___ Change an enrollee's PCCM;

- 9. ___ Institute a restriction on the types of enrollees;
- 10. ___ Further limit the number of assignments;
- 11. ___ Ban new assignments;
- 12. ___ Transfer some or all assignments to different PCCMs;
- 13. ___ Suspend or terminate PCCM agreement;
- 14. ___ Suspend or terminate as Medicaid providers; and
- 15. ___ Other (explain):

c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

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

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

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

The contractor will be responsible for arranging the provision of covered services to beneficiaries. Covered services shall be administered, or arranged for, by a dental provider who is a member of the contractor's network, unless otherwise authorized by the contractor. The contractor must ensure that this delivery system shall provide available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services.

The Department considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be important. The contractor must assure that beneficiaries have access to all dental services in the same manner as other subscribers. In addition, the contractor shall not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

The contractor must have contracts with all providers who deliver dental care services through the contractor's network. These contracts are subject to Department review and approval and must meet the following minimum criteria:

- **include provisions to hold the beneficiaries harmless and ensure continuation of benefits**
- **provide that any dental records, required data, reports of services, or reports on complaints, grievances, quality or utilization issues for beneficiaries must be**

- made available to the contractor, the Department and/or CMS in an appropriate manner**
- **require the provider to cooperate with the Contractor's quality improvement and utilization review activities**
 - **require providers to accept Medicaid beneficiaries along with all other beneficiaries of the Contractor and not segregate them in any way or treat them in a location or manner different from other beneficiaries**
 - **include provisions for contract termination by either party with a minimum of forty-five (45) calendar days written notice and provision to assist beneficiaries enrolled in a closed panel plan in finding a new dental provider before contract termination occurs.**

- **Section A: Program Description**

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

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

___ 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.

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

2. Details

a. Scope of Marketing

1. ___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2. **XX** 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. **Marketing is not really applicable as all eligible enrollees are automatically enrolled into single Dental Contractor.**

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

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

1. **XX** 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. **There are no potential enrollees; Michigan automatically enrolls eligible beneficiaries into single Contractor.**
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 into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

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

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. ___ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

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.

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

2. Details.

a. **Non-English Languages**

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

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

1. ___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. ___ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3. XX Other (please explain): **The Contractor will utilize the same services that are available to the commercial population for Beneficiaries who speak an alternative language**

XX Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken. **All Beneficiary services must address the need for culturally appropriate interventions. In order to provide necessary dental services, reasonable accommodation must be made for Beneficiaries with hearing and/or vision impairments and/or other health care needs.**

XX The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe. **All Beneficiary services must address the need for culturally appropriate interventions. In order to provide necessary dental services, reasonable accommodation must be made for Beneficiaries with hearing and/or vision impairments and/or other health care needs.**

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify) _____

XX There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP) **Beneficiaries are automatically enrolled into a single dental contractor (selective contracting program).**

c. Enrollee Information

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

- (i) the State
- (ii) State contractor (please specify):

(ii) **XX** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider. **Contractor is required to provide a handbook and provider directory with the following information:**

- a table of contents,
- (for a Dental Provider Directory) provider name, address, telephone number, and information on how to choose and change dentists,
- a toll free number for the dental plan explaining member benefits,
- a description of all available contract services and an explanation of any service limitations or exclusions from coverage,

- **information regarding the grievance and complaint process including how to register a complaint with the Contractor, and/or the State, and how to file a written grievance,**
- **what to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. Instructions on how to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations,**
- **information on the process of referral to dental specialists and other providers,**
- **information on how to handle out of service area and out of state services,**
- **description of Beneficiary/Beneficiary family's responsibilities,**
- **and any other information deemed essential by the Contractor and/or the Department.**

C. Enrollment and Disenrollment

1. Assurances.

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

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

___ 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.

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

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

a. XX 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: **All eligible enrollees are automatically enrolled with single Dental Contractor. Once enrolled, the Dental Contractor is required to provide oral health education to the extent that the covered Beneficiary's family is apprised of the appropriate use of health care and instructed in ways to assist in the maintenance of the Beneficiary's oral health. The Contractor will be responsible for developing and maintaining Beneficiary education programs designed to provide the family with clear, concise, and accurate information about the Contractor's services. Beneficiary education materials should include, but are not limited to the following:**

- Member handbook

- **Bulletins or newsletters (e.g., Healthy Living newsletter) sent to the Beneficiaries at least two times a year which provide updates related to covered services, access to providers and updated policies and procedures**

b. **Administration of Enrollment Process.**

XX State staff conducts the enrollment process. **Enrollment is done automatically by MMIS system when beneficiary resides in a county served by Dental Contractor.**

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

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

Broker name: _____

Please list the functions that the contractor will perform:

___ choice counseling

___ enrollment

___ other (please describe):

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

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

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

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

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

i. ___ Potential enrollees will have ___ days/month(s) to choose a plan.

ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether

or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- The State **automatically enrolls** beneficiaries
___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

Enrollment is automatic. All Medicaid beneficiaries in the Dental Contractor's service area are automatically enrolled into the Dental plan.

- ___ 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.

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.

XX 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.

All Medicaid beneficiaries in the Dental Contractor's service area are automatically enrolled into the Dental plan. Enrollees may change between providers within the single Dental Contractor.

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

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

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

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

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

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

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

D. Enrollee rights.

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

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

XX 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.

E. Grievance System

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

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

XX The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

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

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

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

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

3. **Details for MCO or PIHP programs.**

a. **Direct access to fair hearing.**

- The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
- The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

- The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ___ 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.

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

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

- The grievance procedures is operated by:
 - the State
 - the State's contractor. Please identify: _____
 - the PCCM
 - the PAHP.

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

- ___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

- ___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

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

- ___ Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process_____

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

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

- ___ Other (please explain):

F. Program Integrity

1. Assurances.

XX 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 excluded under 1128(b)(8) as being controlled by a sanctioned individual.

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing NO	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data												
Data Analysis (non-claims)												
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing NO	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman												
On-Site Review	2.5		1.2	Sec 5	Sec 3	3.6/3.7	3.8/3.11	2.3		2.6/2.7	Sec 4/3.1	
Performance Improvement Projects												
Performance Measures											PMR	
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe)												

Monitoring Activity	Evaluation of Program Impact					Evaluation of Access				Evaluation of Quality		
	Choice	Marketing NO	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care

II. Details of Monitoring Activities

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

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

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

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

Michigan does not have accreditation standards for dental plans.

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

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

- c. XX Consumer Self-Report data
- CAHPS (please identify which one(s))
 - State-developed survey
 - Disenrollment survey
 - Consumer/beneficiary focus groups

XX **Other (Enrollee Satisfaction Survey administered by the Contractor.**

- d. _____ Data Analysis (non-claims)
 _____ Denials of referral requests
 _____ Disenrollment requests by enrollee
 _____ From plan
 _____ From PCP within plan
 _____ Grievances and appeals data
 _____ PCP termination rates and reasons
 _____ Other (please describe)
- e. XX Enrollee Hotlines operated by State
- f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
- g. XX Geographic mapping of provider network. **Geographic mapping is performed by the Contractor and reviewed by the State at the annual compliance review.**
- h. XX Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods). **DCH currently implementing the process to conduct the independent assessment.**
- i. _____ Measurement of any disparities by racial or ethnic groups
- j. XX Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP] **Reviewed as part of the annual compliance review.**
- k. _____ Ombudsman
- l. XX On-site review
- m. _____ Performance Improvement projects [**Required** for MCO/PIHP]
 _____ Clinical
 _____ Non-clinical
- n. _____ Performance measures [**Required** for MCO/PIHP]
 Process
 Health status/outcomes
 Access/availability of care
 Use of services/utilization
 Health plan stability/financial/cost of care

Health plan/provider characteristics
Beneficiary characteristics

- o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver
- p. _____ Profile utilization by provider caseload (looking for outliers)
- q. _____ Provider Self-report data
 - _____ Survey of providers
 - _____ Focus groups
- r. NA Test 24 hours/7 days a week PCP availability
- s. _____ Utilization review (e.g. ER, non-authorized specialist requests)
- t. _____ Other: (please describe)

Section C: Monitoring Results

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

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

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

XX This is a renewal request.

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

___ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy: Compliance Review

Confirmation it was conducted as described:

XX Yes

___ No. Please explain:

Summary of results:

During the compliance review, the State found potential problems with four areas of the Contractor's operations:

- 1. Provider Contracts**
- 2. Quality**
- 3. Grievance/Appeal Procedures**
- 4. Enrollee Services**

Problems identified (#1):

The State mandates Contractors to have specific provisions in the provider contractors that protect the enrollee-provider relationship. For example, provider contractors must state that providers are not prohibited from advocating on behalf of the Enrollee in any grievance or utilization review process. Similarly, provider contractor are required to specifically require providers to address the cultural, racial and linguistic needs of the population. The Contractors current provider contracts do not clearly delineate and include all requirement provisions.

Corrective action (plan/provider level) (#1):

The Contractor must modify provider contractor to include all required provisions

Problems identified (#2):

The contract between the State and the Contractor includes specific components of a comprehensive quality program that must be present in the Contractors operations. During the compliance review, the State found that the Contractor's Quality of Care policy does not sufficiently describe the Peer Review process used by the Contractor. Additionally, the Contractor's implementation and usage of performance outcome standards with emphasis on preventative care does not fully achieve the State's expectations.

Corrective action (plan/provider level) (#2):

The Quality of Care policy is re-written to specify the steps in the process and the agency used for Peer Review. DCH is working with the Contractor to develop and implement measurable performance outcomes standards.

Problems identified (#3):

As part the compliance review, the State reviewed the Contractor's grievance and appeal procedures/policies. During the review, the State determined that not all of the written documentation regarding service denials includes specific reasons for the denial.

Corrective action (plan/provider level) (#3):

The Contractor's Adverse Benefit Determination Appeal policy states that written correspondence sent to the enrollee must include the reason(s) for the denial. Therefore, the policy to correct the deficiency is already in place. The State is

requiring the Contractor to develop a formal plan for monitoring denial correspondence to ensure that all elements are present in each denial.

Problems identified (#4):

The State mandates that all member reading materials are below a 7th grade reading level. However, certain sections of the member handbook do not meet this requirement. Additionally, the handbook does not include all required provisions related to enrollee access.

Corrective action (plan/provider level) (#3):

The Contractor must re-write the member handbook to meet all contractual and regulatory requirements.

Program change (system-wide level): **In the next annual compliance review, DCH intends to add criteria dealing with coordination/continuity of care as well as prior authorization procedures. DCH will also make contract changes to ensure that the State can hold the Contractor responsible for performing required quality activities.**

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

- Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
Richard Miles _____
- c. Telephone Number: 517 373 2378 _____
- d. E-mail: miles@michigan.gov _____
- e. The State is choosing to report waiver expenditures based on
 X date of payment.
 ___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

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

- a. ___ MCO
- b. ___ PIHP
- c. ___ PAHP
- d. x Other (please explain): Selective contracting program

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

For Conversion or Renewal Waivers:

- a. x [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. x For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. x [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: The increase in member months reflects enrollment trends for the Michigan Medicaid program.
- 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: All calculations are based on the waiver period, which is from April through March.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: There are no different services included.

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

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

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

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2

Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

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

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. ___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. x Other (Please explain). No administrative costs are being allocated. An adjustment for administration is included for the external review in P2

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.

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>

Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		(PMPM in Appendix D5 Column W x projected member months should correspond)

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,751,500 or \$.97 PMPM R1</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1</i>
	<i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i>		<i>\$2,291,216 or 1.10 PMPM in P2</i>
Total	(PMPM in Appendix D3 Column H x member months should correspond)		(PMPM in Appendix D5 Column W x projected member months should correspond)

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

- c. ___ 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 (please describe):
- 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.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
 2. ___ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in

addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)

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

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
 1. ____ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

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

Others:

 - Additional State Plan Services (+)
 - Reductions in State Plan Services (-)

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

- B. ___ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA.
PMPM size of adjustment _____
- D. ___ Other (please describe):

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

- 1. ___ No adjustment was necessary and no change is anticipated.
- 2. ___ An administrative adjustment was made.
 - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
 - ii. ___ FFS cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
 - iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____ In addition, please indicate the mathematical method used (multiple regression, linear

regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

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

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1.____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2.____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ___ We assure CMS that GME payments are included from base year data.
2. ___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. ___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. ___ GME adjustment was made.
 - i. ___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ___ No adjustment was necessary and no change is anticipated.

Method:

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

- g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.
1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
 2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
 3. ___ The State had no recoupments/payments outside of the MMIS.
- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
- Basis and Method:*
1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ___ Other (please describe):

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

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

Method:

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

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

Basis and method:

1. ___ No adjustment was necessary
2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ___ The State made this adjustment:
 - i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
 - ii. ___ Other (please describe):

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

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
 2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
 3. ___ Other (please describe):
- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
1. ___ We assure CMS that DSH payments are excluded from base year data.
 2. ___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
 3. ___ Other (please describe):
- l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
1. ___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
 2. ___ This adjustment was made:
 - a. ___ Potential Selection bias was measured in the following manner:
 - b. ___ The base year costs were adjusted in the following manner:
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4. ___ Other (please describe):

Special Note section:

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

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

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

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

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem

Adjustment	Capitated Program	PCCM Program
	Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.
Documentation of assumptions and estimates is required for this adjustment.
1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 3. ___ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 2. ___ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

- ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The**

State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1. [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:

15.15%. Please document how that trend was calculated: Cost PMPM for P1 assumes the first six months at the established known rate of \$17.90, increased from \$16.43, as of October 1 of 2010. The second six months reflects that same rate (\$17.90) increased by 5.21% (based on historical rate experience). The amount for all of D1 is an average of those two periods. The percentage increase indicated reflects the increase from the base year rate of \$16.43 to the average P1 rate of \$18.37. D2 uses a similar methodology and assumes another 5.21% increase based on historical rate changes effective October of 2012 (in effect for the last two quarters of P2).

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 State Fiscal Years 2007 – 2011. 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. An average trend rate of 5.21% is applied to periods beginning October 1, 2011 based on historical and known experience. Actual rates are known for historical periods back to the beginning of state fiscal year 2007. While fiscal year 2011 is not historical, the current capitation rate is an established amount (through September of 2011).

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). Actual rate experience for rate years effective beginning in FY 2007.
- ii. Please document how the utilization did not duplicate separate cost increase trends. Only actual paid capitation rates are incorporated into the calculation of an estimated increase for the Healthy Kids Dental program for P1 and P2.

b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:**

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

Others:

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

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

- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ *Determine adjustment for Medicare Part D dual eligibles.***
 - E. ___ Other (please describe):
- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

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

1. No adjustment was necessary and no change is anticipated.

2. ___ An administrative adjustment was made.

i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii. ___ Cost increases were accounted for.

A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

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

C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. Other (please describe): Adjustment was made in P2 to cover the estimated cost of an external review.

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the

State's cost increase calculation includes more factors than a price increase.

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

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
1. ____ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____ . Please provide documentation.
 2. ____ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
 - i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years _____
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): _____
 - ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** _____
 3. Explain any differences: _____
- f. **Other Adjustments** including but not limited to federal government changes. (Please describe):
- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

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

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d: The increase in member months reflects enrollment trends for the Michigan Medicaid program.**
 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: Trend rate is based on historical and known experience. Actual rates date back to historical periods beginning with state fiscal year 2007. While fiscal year 2011 is not historical, the current capitation rate is an established amount (through September of 2011).**
 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:**

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

Part II: Appendices D1-7

Please see attached Excel spreadsheets.

Appendix D1. Member Months

Row # / Column Letter	B	C	D	E	F	G	H	I	J	K	L	M	N	
2	Renewal Waiver													
3	Estimated Member Month Calculations													
4	State: Michigan													
5	Actual Enrollment for the Time Period -	R1 =	4/1/2009	through	3/31/2010	R2 =	4/1/2010	through	3/30/2010	**R1 and R2 include actual data and dates used in conversion - no estimates				
6	Enrollment Projections for the Time Period -	P1 =	4/1/2011	through	3/31/2012	P2 =	4/1/2012	through	3/31/2013	*Projections start on Quarter and include data for requested waiver period				
7	Medicaid Eligibility Group (MEG)	Retrospective Year 1 ends (R1)	Retrospective Year 2 ends (R2)	Projected Quarter 1	Projected Quarter 2	Projected Quarter 3	Projected Quarter 4	Projected Year 1 (P1)	Projected Quarter 5	Projected Quarter 6	Projected Quarter 7	Projected Quarter 8	Projected Year 2 (P2)	Total Projected (H+M)
8		3/31/2010	9/30/2010	4/1/2011	7/1/2011	9/30/2011	12/31/2011		4/1/2012	6/30/2012	9/29/2012	12/30/2012		
9	Healthy Kids Dental	3,830,332	1,894,733	976,073	985,833	995,692	1,005,648	3,963,246	1,015,705	1,025,862	1,036,121	1,046,482	4,124,170	8,087,416
10	MEG 2							0					0	0
11	MEG 3							0					0	0
12	MEG 4							0					0	0
13	Total Member Months	3,830,332	1,894,733	976,073	985,833	995,692	1,005,648	3,963,246	1,015,705	1,025,862	1,036,121	1,046,482	4,124,170	8,087,416
14	Quarterly % Increase				1.00%	1.00%	1.00%		1.00%	1.00%	1.00%	1.00%		
15	Annualized % Increase R1 to R2 to P1 to P2		4.38%					4.59%					4.06%	

NUMBER OF DAYS OF DATA	
R2	182.00
Gap (end of R2 to P1)	-183.00
P1	365.00
P2	364.00
TOTAL R2 to P2	728
(Days-365)	363
TOTAL R2 to P1	364
(Days-364)	-1

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

State Completion Sections

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

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

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

Appendix D2.S Services in Waiver Cost

Row # /
Column
Letter

B C D E F G H I

Services in Actual Waiver Cost (Comprehensive and Expedited)

State: Michigan

Renewal Waiver

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

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

State Plan Services	State Plan Approved Services	1915(b)(3) Services	MCO Capitated Reimbursement	FFS services Impacted by MCO	PCCM Fee-for Service Reimbursement	PIHP Capitated Reimbursement	PIHP Fee-for Service Reimbursement	PAHP Capitated Reimbursement	PAHP Fee-for Service Reimbursement
Inpatient Hospital (includes psych)									
IHS Inpatient									
Mental Health Facility									
Skilled Nursing Home									
ICF-MR Public									
ICF-MR Private									
ICF-Other									
Physician Services (includes psych)									
Outpatient Hospital (includes psych)									
IHS Outpatient									
Prescribed Drugs									
Dental Services								X	
Other Practitioners (includes psych)									
Clinic Services									
Lab or Radiology (includes psych)									
Home Health Services									
Sterilizations									
EPSDT Screening									
Rural Health Clinic									
FQHC									
Tribal 638									
HCBS Waivers									
Personal Care									
Other Care Services									
Family Planning									
Targeted Case Mgmt - MR Waiver									
Individualized Alternative or Enhanced Services									
PCCM Case Management Fees									
Managed Care Capitated Services									
Targeted Case Mgmt - MH/SA									

Appendix D3. Actual Waiver Cost

Row # /
Column
Letter

B C D E F G H I J

Actual Waiver Cost Renewal Comprehensive Version
State: Michigan

4
5
6

Medicaid Eligibility Group (MEG)	R1 Member Months	Retrospective Year 1 (R1) Aggregate Costs							Total Actual Waiver Costs (F+G+H+I)
		MCO/PIHP/PAHP Capitated Costs (Including Incentives and risksharing payouts/withholds or PCCM Case Management Fees)	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs		
Healthy Kids Dental	3,630,332	\$ 58,320,917		\$ 58,320,917				\$ 58,320,917	
MEG 2	-			\$ -				\$ -	
MEG 3	-			\$ -				\$ -	
MEG 4	-			\$ -				\$ -	
Total	3,630,332	\$ 58,320,917	\$ -	\$ 58,320,917	\$ -	\$ -	\$ -	\$ 58,320,917	
R1 Overall PMPM Casemix for R1 (R1 MMs)									

19

Medicaid Eligibility Group (MEG)	R2 Member Months	Retrospective Year 2 (R2) Aggregate Costs							Total Actual Waiver Costs (F+G+H+I)
		MCO/PIHP Capitated Costs (Including incentives and risksharing payouts/withholds or PCCM Case Management Fees)	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs (Attach list using CMS 64.10 Waiver schedule categories)		
Healthy Kids Dental	1,894,733	\$ 30,632,007		\$ 30,632,007				\$ 30,632,007	
MEG 2	-			\$ -				\$ -	
MEG 3	-			\$ -				\$ -	
MEG 4	-			\$ -				\$ -	
Total	1,894,733	\$ 30,632,007	\$ -	\$ 30,632,007	\$ -	\$ -	\$ -	\$ 30,632,007	
R1 Overall PMPM Casemix for R2 (R2 MMs)									

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

Note: The States completing the Expedited Test will only attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver. Completion of this Appendix is not necessary for expedited waivers.

Note: The States completing the Comprehensive Test will attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver. Completion of this Appendix is required for Comprehensive Waivers.

Appendix D3. Actual Waiver Cost

Row # /
Column
Letter

B C K L M N O

Actual Waiver Cost Renewal Comprehensive Version
State: Michigan

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5
6

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17
18

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 Per Member Per Month (PMPM) Costs					Total Actual Waiver Costs (J/C)
		State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)		
Healthy Kids Dental	3,630,332	\$ 16.06	\$ -	\$ -	\$ -	\$ 16.06	
MEG 2	-						
MEG 3	-						
MEG 4	-						
Total	3,630,332						
R1 Overall PMPM Casemix for R1 (R1 MMs)		\$ 16.06	\$ -	\$ -	\$ -	\$ 16.06	

19

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22
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30
31

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 Per Member Per Month (PMPM) Costs					Total Actual Waiver Costs (J/C)
		State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)		
Healthy Kids Dental	1,894,733	\$ 16.17	\$ -	\$ -	\$ -	\$ 16.17	
MEG 2	-						
MEG 3	-						
MEG 4	-						
Total	1,894,733						
R2 Overall PMPM Casemix for R2 (R2 MMs)		\$ 16.17	\$ -	\$ -	\$ -	\$ 16.17	

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

Appendix D4. Adjustments in Projection

Row # /
Column
Letter

B

C

D

Adjustments and Services in Waiver Cost Projection (Comprehensive and Expedited)

State: Michigan

Prospective Years 1 and 2 (P1 and P2)

Renewal Waiver

* If a change please note

2
2
4
5
6
7
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11
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15

Adjustments to the Waiver Cost Projection	Adjustments Made	Location of Adjustment
State Plan Trend	X	Appendix D5: J13 and J30
State Plan Programmatic/policy/pricing changes		
Administrative Cost Adjustment	x	Appendix D5: AA30
1915(b)(3) service Trend		
Incentives (not in cap payment) Adjustments		
Other		

State Completion Sections

Appendix D2.A Administration in Waiver Cost

Row # /
Column
Letter

B

C

D

E

F

G

H

I

Administration in Actual Waiver Cost (Comprehensive and Expedited)

State: Michigan

Renewal Waiver

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

CMS 64.10 Line Item	CMS 64.10 Explanation	Contract	Match Rate	BY Expenses
1	FAMILY PLANNING		90% FFP	
2	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS*		90% FFP	
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		90% FFP	
B.	COST OF PRIVATE SECTOR CONTRACTORS		90% FFP	
C.	DRUG CLAIMS SYSTEM		90% FFP	
3	SKILLED PROFESSIONAL MEDICAL PERSONNEL		75% FFP	
4	OPERATION OF AN APPROVED MMIS*		75% FFP	
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		75% FFP	
B.	COST OF PRIVATE SECTOR CONTRACTORS		75% FFP	
5	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES:		50% FFP	
A.	COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		50% FFP	
B.	COST OF PRIVATE SECTOR CONTRACTORS		50% FFP	
6	PEER REVIEW ORGANIZATIONS (PRO)		75% FFP	
7. A.	THIRD PARTY LIABILITY RECOVERY PROCEDURE - BILLING OFFSET		50% FFP	
B.	ASSIGNMENT OF RIGHTS - BILLING OFFSET		50% FFP	
8	IMMIGRATION STATUS VERIFICATION SYSTEM COSTS		100% FFP	
9	NURSE AIDE TRAINING COSTS		50% FFP	
10	PREADMISSION SCREENING COSTS		75% FFP	
11	RESIDENT REVIEW ACTIVITIES COSTS		75% FFP	
12	DRUG USE REVIEW PROGRAM		75% FFP	
13	OUTSTATIONED ELIGIBILITY WORKERS		50% FFP	
14	TANF BASE		90% FFP	
15	TANF SECONDARY 90%		90% FFP	
16	TANF SECONDARY 75%		75% FFP	
17	EXTERNAL REVIEW	150,000	75% FFP	112,500
18	ENROLLMENT BROKERS		50% FFP	
19	OTHER FINANCIAL PARTICIPATION		50% FFP	
20	Total			\$ 112,500

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

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

State Completion Sections

Appendix D5. Waiver Cost Projection

Row # / Column Letter

Waiver Cost Projection Renewal Waiver Comprehensive Version

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

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	R2 Per Member Per Month (PMPM) Costs					Prospective Year 1 (P1) Projection for State Plan Services**						
		State Plan Service Costs*	Incentive Costs*	1915(b)(3) Service Costs*	Administration Costs*	Total Actual Waiver Costs*	R2 PMPM State Plan Service Costs* (Same as D13-D18)	State Plan Inflation Adjustment (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (KJ)	Program Adjustment [Enter Description Here] (Preprint Explains)	PMPM Effect of Program Adjustment ((+K)/L)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P1 PMPM State Plan Service Cost Projection ((+N)
Healthy Kids Dental	1,894,733	\$ 16.17	\$ -	\$ -	\$ -	\$ 16.17	\$ 16.17	13.60%	\$ 2.20		\$ -	\$ 2.20	\$ 16.37
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
Total	1,894,733												
P1 PMPM Casemix for R2 (R2 MM)		\$ 16.17	\$ -	\$ -	\$ -	\$ 16.17	\$ 16.17	13.60%	\$ 2.20	0.0%	\$ -	\$ 2.20	\$ 16.37

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

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P1 Per Member Per Month (PMPM) Costs					Prospective Year 2 (P2) Projection for State Plan Services**						
		P1 PMPM State Plan Service Costs (same as O13-O18)	P1 PMPM Incentive Service Costs (same as S13-S18)	P1 PMPM 1915(b)(3) Service Costs (same as W13-W18)	P1 PMPM Administration Service Costs (same as AA13-AA18)	P1 PMPM Total Actual Waiver Costs (same as AB13-AB18)	P1 PMPM State Plan Service Cost Projection (Same as D30-D35)	State Plan Inflation Adjustment (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (KJ)	Program Adjustment [Enter Description Here] (Preprint Explains)	PMPM Effect of Program Adjustment ((+K)/L)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P2 PMPM State Plan Service Cost Projection ((+N)
Healthy Kids Dental	1,894,733	\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	\$ 16.37	6.21%	\$ 0.96		\$ -	\$ 0.96	\$ 16.32
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -		\$ -	\$ -	\$ -
Total	1,894,733												
P2 PMPM Casemix for R2 (R2 MM)		\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	\$ 16.37	6.21%	\$ 0.96	0.0%	\$ -	\$ 0.96	\$ 16.32

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

Appendix D5. Waiver Cost Projection

Row # / Column Letter

Walver Cost Projection Renewa

Actual Waiver Cost Conversion Renewal Comprehensive Version
 State: Michigan
 Note: Complete this Appendix for all Prospective Years
 Waiver Cost Projection

Medicaid Eligibility Group (MEG)	P1 Projection for Incentive Costs not				P1 Projection for 1915(b)(3) Service Costs**				P1 Projection for Administration Costs**				Total P1 PMPM Projected Waiver Costs (G+H+W+AA)		
	R2 PMPM Incentive Costs* (Same as E13-E18)	Incentive Cost Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P1 PMPM Incentive Cost Projection (P+R)	R2 PMPM 1915(b)(3) Service Costs* (Same as F13-F18)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P1 PMPM 1915(b)(3) Service Cost Projection (T+V)	R2 PMPM Administration Costs* (Same as G13-G18)	Administration Costs Inflation Adj. (Annual Year 1) (Preprint Explains)	PMPM Effect of Inflation Adjustment (XxY)	Total P1 PMPM Administration Cost Projection (X+Z)			
Healthy Kids Dental	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	19.37
MEG 2	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 3	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 4	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
Total															
P1 PMPM Casemix for R2 (R2 MMs)	\$ -	0.00%	\$ -	\$ -	\$ -	0.00%	\$ -	\$ -	\$ -	0.00%	\$ -	\$ -	\$ -	\$ -	19.37

Medicaid Eligibility Group (MEG)	P2 Projection for Incentive Costs not included in Capitation Rates**				P2 Projection for 1915(b)(3) Service Costs**				P2 Projection for Administration Costs**				Total P2 PMPM Projected Waiver Costs (D+S+W+AA)		
	P1 PMPM Incentive Cost Projection (Same as E30-E36)	Incentive Cost Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (PxQ)	Total P2 PMPM Incentive Cost Projection (P+R)	P1 PMPM 1915(b)(3) Service Cost Projection (Same as F30-F36)	1915(b)(3) Service Costs Inflation Adj. (Annual Year 2) (Preprint Explains)	PMPM Effect of Inflation Adjustment (TxU)	Total P2 PMPM 1915(b)(3) Service Cost Projection (T+V)	P1 PMPM Administration Cost Projection (Same as G30-G36)	Administration Costs Inflation Adj. (Annual Year 2)	PMPM Effect of Inflation Adjustment (XxY)	Total P2 PMPM Administration Cost Projection (X+Z)			
Healthy Kids Dental	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	0.05	19.37
MEG 2	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 3	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 4	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -	\$ -
Total															
P2 PMPM Casemix for R2 (R2 MMs)	\$ -	0.00%	\$ -	\$ -	\$ -	0.00%	\$ -	\$ -	\$ -	0.00%	\$ -	\$ -	\$ -	\$ -	19.37

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

Appendix D6. RO Targets

Row # / Column Letter

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

Quarterly CMS Targets for RO Monitoring
State: Michigan
Projection for Upcoming Waiver Period

Projected Year 1

Medicaid Eligibility Group (MEG)	Total Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs from Appendix D6 (Totals weighted on Projected Year 1 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1815(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Healthy Kids Dental	3,063,246	\$ 18.37	\$ -	\$ -	\$ -	\$ -	\$ 18.37
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	3,063,246	\$ 18.37	\$ -	\$ -	\$ -	\$ -	\$ 18.37
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		\$ 18.37	\$ -	\$ -	\$ -	\$ -	\$ 18.37

Medicaid Eligibility Group (MEG)	Member Months Projections	Q1 Quarterly Projected Costs		Q2 Quarterly Projected Costs		Q3 Quarterly Projected Costs		Q4 Quarterly Projected Costs		Total P1 Projected Waiver Costs			
		64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs				
Healthy Kids Dental	976,073	\$ 17,926,838.27	\$ -	\$ 985,833	\$ 18,106,106.60	\$ -	\$ 985,692	\$ 18,287,187.72	\$ -	\$ 1,005,649	\$ 18,470,039.40	\$ -	\$ 72,790,152.06
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	976,073	\$ 17,926,838.27	\$ -	\$ 985,833	\$ 18,106,106.60	\$ -	\$ 985,692	\$ 18,287,187.72	\$ -	\$ 1,005,649	\$ 18,470,039.40	\$ -	\$ 72,790,152.06

Projected Year 2

Medicaid Eligibility Group (MEG)	Total Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs from Appendix D6 (Totals weighted on Projected Year 2 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1815(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Healthy Kids Dental	4,124,170	\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	4,124,170	\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	

Medicaid Eligibility Group (MEG)	Member Months Projections	Q1 Quarterly Projected Costs		Q2 Quarterly Projected Costs		Q3 Quarterly Projected Costs		Q4 Quarterly Projected Costs		Total P2 Projected Waiver Costs			
		64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs	64.0W /64.21U W Service Costs Include Incentives	64.10 Waiver Administration Costs				
Healthy Kids Dental	1,015,705	\$ 19,620,651.74	\$ 80,785.28	\$ 1,025,802	\$ 19,822,918.26	\$ 51,293.11	\$ 1,036,121	\$ 20,021,147.44	\$ 51,806.04	\$ 1,046,462	\$ 20,221,358.91	\$ 52,324.10	\$ 79,889,284.85
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	1,015,705	\$ 19,620,651.74	\$ 80,785.28	\$ 1,025,802	\$ 19,822,918.26	\$ 51,293.11	\$ 1,036,121	\$ 20,021,147.44	\$ 51,806.04	\$ 1,046,462	\$ 20,221,358.91	\$ 52,324.10	\$ 79,889,284.85

Appendix D6. RO Targets

P Q R S T U

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

Projected Year 1 4/1/2011 through 3/31/2012

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs 8/30/2011	Q2 Quarterly Projected Costs 9/29/2011	Q3 Quarterly Projected Costs 12/08/2011	Q4 Quarterly Projected Costs 3/01/2012
64.21U Waiver Form	Healthy Kids Dental	\$ 17,926,538.27	\$ 18,106,100.66	\$ 18,267,167.72	\$ 18,470,039.40
64.21U Waiver Form	MEG 2	\$ -	\$ -	\$ -	\$ -
64.9 Waiver Form	MEG 3	\$ -	\$ -	\$ -	\$ -
64.9 Waiver Form	MEG 4	\$ -	\$ -	\$ -	\$ -
64.10 Waiver Form		\$ -	\$ -	\$ -	\$ -

Projected Year 1 4/1/2012 through 3/31/2013

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs 8/23/2012	Q2 Quarterly Projected Costs 9/24/2012	Q3 Quarterly Projected Costs 12/28/2012	Q4 Quarterly Projected Costs 3/21/2013
64.21U Waiver Form	Healthy Kids Dental	\$ 19,526,551.74	\$ 19,822,918.26	\$ 20,021,147.44	\$ 20,221,358.91
64.21U Waiver Form	MEG 2	\$ -	\$ -	\$ -	\$ -
64.9 Waiver Form	MEG 3	\$ -	\$ -	\$ -	\$ -
64.9 Waiver Form	MEG 4	\$ -	\$ -	\$ -	\$ -
64.10 Waiver Form		\$ 50,785.26	\$ 51,293.11	\$ 51,806.04	\$ 52,324.10

Appendix D6. RO Targets

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

Quarterly CMS Targets for RO Cost-Effectiveness Monitoring

State: Michigan

Projection for Upcoming Waiver Period

Worksheet for RO PMPM Cost-Effectiveness Monitoring

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P1 Projected PMPM From Column I (Services)	From Column G (Administration)
64.21U Waiver Form	Healthy Kids Dental	\$	19.37
64.21U Waiver Form	MEG 2	\$	-
64.9 Waiver Form	MEG 3	\$	-
64.9 Waiver Form	MEG 4	\$	-
64.10 Waiver Form	All MEGs	\$	-

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Q1 Quarterly Actual Costs			Q2 Quarterly Actual Costs			Q3 Quarterly Actual Costs			Q4 Quarterly Actual Costs		
		Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	Healthy Kids Dental	49724			49816			49807			40995		
64.21U Waiver Form	MEG 2												
64.9 Waiver Form	MEG 3												
64.9 Waiver Form	MEG 4												
64.10 Waiver Form	All MEGs												

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P1 Projected PMPM From Column I (Services)	From Column G (Administration)
64.21U Waiver Form	Healthy Kids Dental	\$	19.32
64.21U Waiver Form	MEG 2	\$	-
64.9 Waiver Form	MEG 3	\$	-
64.9 Waiver Form	MEG 4	\$	-
64.10 Waiver Form	All MEGs	\$	0.05

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Q1 Quarterly Actual Costs			Q2 Quarterly Actual Costs			Q3 Quarterly Actual Costs			Q4 Quarterly Actual Costs		
		Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.21U Waiver Form	Healthy Kids Dental	41090			41180			41272			41364		
64.21U Waiver Form	MEG 2												
64.9 Waiver Form	MEG 3												
64.9 Waiver Form	MEG 4												
64.10 Waiver Form	All MEGs												

Appendix D7. Summary

Row # / Column Letter

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

Cost Effectiveness Summary Sheet Renewal Waiver
State: Michigan

Retrospective Period

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 Per Member Per Month (PMPM) Costs					R1 PMPM Total Actual Waiver Costs
		R1 PMPM State Plan Service Costs	R1 PMPM Incentive	R1 PMPM 191(K)(5) Service Costs	R1 PMPM Administration Costs	R1 PMPM Total Actual Waiver Costs	
Healthy Kids Dental	3,830,332	\$ 16.00	\$ -	\$ -	\$ -	\$ 16.00	
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	3,830,332	\$ 16.00	\$ -	\$ -	\$ -	\$ 16.00	
R1 Overall PMPM Casemix for R1 (R1 MMs)		\$ 16.00	\$ -	\$ -	\$ -	\$ 16.00	
Total R1 Expenditures		\$ 61,285,312	\$ -	\$ -	\$ -	\$ 61,285,312	

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

P1 Per Member Per Month (PMPM) Costs from the prior waiver submission				
P1 PMPM State Plan Service Costs	P1 PMPM Incentive Costs	P1 PMPM 191(K)(5) Service Costs	P1 PMPM Administration Costs	P1 PMPM Total Actual Waiver Costs
\$ 16.00	\$ -	\$ -	\$ -	\$ 16.00
\$ 16.00	\$ -	\$ -	\$ -	\$ 16.00
Total Previous P1 Projection using R1 member months \$ 61,285,312				

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 Per Member Per Month (PMPM) Costs (Totals weighted on Retrospective Year 2 Member Months)					Overall R1 to R2 Change (annual)
		R2 PMPM State Plan Service Costs	R2 PMPM Incentive	R2 PMPM 191(K)(5) Service Costs	R2 PMPM Administration Costs	R2 PMPM Total Actual Waiver Costs	
Healthy Kids Dental	1,694,733	\$ 10.17	\$ -	\$ -	\$ -	\$ 10.17	
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	1,694,733	\$ 10.17	\$ -	\$ -	\$ -	\$ 10.17	
R2 Weighted Average PMPM Casemix for R1 (R1 MMs)		\$ 10.17	\$ -	\$ -	\$ -	\$ 10.17	
R2 Overall PMPM Casemix for R2 (R2 MMs)		\$ 10.17	\$ -	\$ -	\$ -	\$ 10.17	
Total R2 Expenditures		\$ 17,250,000	\$ -	\$ -	\$ -	\$ 17,250,000	

P2 Per Member Per Month (PMPM) Costs from the prior waiver submission				
P2 PMPM State Plan Service Costs	P2 PMPM Incentive Costs	P2 PMPM 191(K)(5) Service Costs	P2 PMPM Administration Costs	P2 PMPM Total Actual Waiver Costs
\$ 17.50	\$ -	\$ -	\$ -	\$ 17.50
\$ 17.50	\$ -	\$ -	\$ -	\$ 17.50
Total Previous P2 Projection using R2 member months \$ 29,671,616				

Total Previous Waiver Period Expenditures (Casemix for R1 and R2) \$0
Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period \$92,516,630

Prospective Period

Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months)					Overall R2 to P1 Change (annual)
		P1 PMPM State Plan Service Cost Projection	P1 PMPM Incentive Cost Projection	P1 PMPM 191(K)(5) Service Cost Projection	P1 PMPM Administration Cost Projection	P1 PMPM Projected Waiver Costs	
MEG 1	3,863,248	\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	3,863,248	\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	
P1 Weighted Average PMPM Casemix for R2 (P2 MMs)		\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	
P1 Weighted Average PMPM Casemix for P1 (P1 MMs)		\$ 16.37	\$ -	\$ -	\$ -	\$ 16.37	
Total Projected Waiver Expenditures P1 (P1 MMs)		\$ 63,210,000	\$ -	\$ -	\$ -	\$ 63,210,000	

Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months)					Overall P1 to P2 Change (annual)
		P2 PMPM State Plan Service Cost Projection	P2 PMPM Incentive Cost Projection	P2 PMPM 191(K)(5) Service Cost Projection	P2 PMPM Administration Cost Projection	P2 PMPM Projected Waiver Costs	
MEG 1	4,124,170	\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
MEG 2	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 3	-	\$ -	\$ -	\$ -	\$ -	\$ -	
MEG 4	-	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	4,124,170	\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		\$ 19.32	\$ -	\$ -	\$ 0.05	\$ 19.37	
Total Projected Waiver Expenditures P2 (P2 MMs)		\$ 80,000,000	\$ -	\$ -	\$ 500,000	\$ 80,500,000	

Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1 + P2)	Overall R1 to P2 Change (daily)	Overall R1 to P2 Change (annualized)
MEG 1	8,087,416	0.05%	20.72%
MEG 2	-		
MEG 3	-		
MEG 4	-		
Total	8,087,416		
P2 Weighted Average PMPM Casemix for R1 (R1 MMs)		\$ 10.17	\$ -
P2 Weighted Average PMPM Casemix for P2 (P2 MMs)		\$ 19.32	\$ 0.05
Total Projected Waiver Expenditures P2 + P1 (Casemix for P1 and P2)		\$ 10.17	\$ 0.05

Modify Line Items as necessary to fit the MEGs of the program.
To modify the formulas as necessary to fit the length of the program complete this section. The formulas will automatically update given this data.
PMPM from previous approved waiver.