

**Proposal for a Section 1915(b) Capitated and PCCM Combined  
Waiver Program**

**Waiver Renewal Submittal**

Submitted by the State of West Virginia  
Department of Health and Human Resources  
Bureau for Medical Services  
March 31, 2014



US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare and Medicaid Services  
Center for Medicaid and State Operations

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**FACESHEET**

The **State** of West Virginia 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 Mountain Health Trust (MHT), which will include the capitated program and Physician Assured Access System (PAAS), the PCCM program.

**Type of request.** This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section A/Part 1
  - 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 July 1, 2014 and ending June 30, 2016.

**State Contact:** The State contact person for this waiver is Brandy Pierce and can be reached by telephone at (304) 356-4912, or fax at (304) 558-4398, or e-mail at Brandy.J.Pierce@wv.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.*

Please note that West Virginia does not have any Federally recognized tribes located in the State.

#### **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).*

This waiver renewal is for West Virginia's full-risk managed care program, Mountain Health Trust (MHT) and the primary care case management program, Physician Assured Access System (PAAS). The current waiver was approved for the period of July 1, 2012, to June 30, 2014. This waiver renewal request is for a two-year period beginning July 1, 2014, and ending June 30, 2016.

In this waiver period, the State requests authority to enroll SSI-eligible beneficiaries (excluding dual eligibles, those in residential settings, and those enrolled in the HCBS waiver programs) into MCOs in this waiver period. BMS will provide an implementation plan and phase-in schedule for enrollment of the SSI population once a transition date is confirmed. The State will submit outreach materials and network documentation prior to SSI implementation in a county.

In addition, the State is requesting a service area expansion for one participating managed care organization (MCO), The Health Plan of the Upper Ohio Valley (THP). The State has reviewed THP's provider network and found it to be adequate for expansion into 13 additional counties: Grant, Hampshire, Hardy, Jefferson, Logan, Mason, Mineral, Mingo, Morgan, Nicholas, Pendleton, Raleigh, and Summers Counties. Currently, a choice of two plans is offered in all of the counties to which THP is trying to expand. Upon CMS approval, each of these counties will operate under the "MCO three plan" model. This service area expansion is described under Section A, Part I, D. Geographic Areas Served by the Waiver. Detailed network documentation is provided in Appendix C-1.

Finally, the State is requesting the authority to allow an additional MCO, West Virginia Family Health (WVFH), to participate in the MHT program. The State has reviewed WVFH's operational and network readiness to provide services to MHT members and has found both elements to be adequate. Upon CMS approval, WVFH will be provided as

an option to members in 53 of 55 counties. This expansion is described under Section A, Part I, D. Geographic Areas Served by the Waiver.

The State is not requesting any other significant changes to waiver authority regarding program structures, benefit packages, managed care eligible populations, access standards, quality standards, or beneficiary protections. Minor changes are incorporated throughout the contract to reflect the current state of the program. In addition, the State is discontinuing the monitoring strategy of comparing numbers of providers before and during the waiver as the waiver has been in place since 1996. Other monitoring strategies, including maintaining access standards for travel time and reviewing PCP panel sizes, are a more effective measure of access.

Outreach and enrollment for the MHT and PAAS programs is handled by a single enrollment broker, Automated Health Systems, Inc (AHSI). Using the same single enrollment broker in both MHT and PAAS facilitates coordination between the programs and ensures that enrollees receive appropriate program information. AHSI is also responsible for tracking enrollment and disenrollment in programs, plans, and providers, which is used by the State in program monitoring.

#### *Mountain Health Trust Capitated Program*

The Mountain Health Trust program has successfully operated in West Virginia for eight waiver periods. We request a renewal of the authority granted to mandate enrollment of TANF and TANF-related children and adults, pregnant women, medically needy, children with special health care needs, and SSI and SSI-related eligibles (excluding dual eligibles) into capitated MCOs statewide.

During the first waiver period (1996-1998), three MCOs contracted with the State, and beneficiaries in all program counties had a choice of two or more MCOs. Just prior to the second waiver period (1998-2000), one of the three MCOs left the program. In some counties only one MCO remained, so beneficiaries in those counties were given the choice between enrollment in the MCO or in the State's PCCM program.

During the third waiver period (2000-2002), West Virginia sought and received approval to amend the waiver and implement the single plan rural option authorized by the Balanced Budget Act of 1997 (BBA). In rural counties where only one MCO was present, Medicaid beneficiaries were enrolled in the MCO and were no longer required to choose between enrolling in the MCO or PCCM program. In December 2003, implementation of the single plan rural option began in two counties. Also during the third waiver period, the State contracted with a third MCO to provide health care services to MHT enrollees. Contracting with this third MCO provided beneficiaries in more counties with a choice of at least two MCOs.

In the fifth waiver period (2006-2008), the State expanded the MCO program considerably, increasing capitated managed care access to 51 of the 55 counties across the State. Over time in the sixth (2008-2010) and seventh (2010-2012) waiver periods,

the MCO program expanded and beneficiaries in all 55 counties had the option to enroll in the MCO program.

There were several program changes in the eighth (2012-2014) waiver period. One of the MCOs expanded statewide, allowing the State to offer a choice of at least two MCOs or one MCO and PAAS in every county. This effectively ended the single plan rural option. The State received approval to cover two additional benefits in the managed care benefit package: pharmacy, which was implemented in April 2013, and children's dental, which was implemented in January 2014. In addition, the State discontinued Mountain Health Choices, which offered Section 1937 benchmark benefit packages authorized under the State Plan, and transitioned those eligibles to Mountain Health Trust.

The current approved waiver allows the MHT program to assign program eligibles in counties where one MCO operates in conjunction with the PAAS program to the full-risk (MCO) option if the person did not make a choice between the MCO and PCCM during the enrollment period.

The State continues to hold MHT Task Force meetings that include representation from the Bureau for Medical Services, MCOs, the enrollment broker, the external quality review organization, and other consultants to the State. These meetings provide the State with a high level of oversight of program administration issues and promote continuous improvement in all aspects of the program (e.g., enrollment, health care delivery, external monitoring). Representatives from other state agencies also attend the quarterly meetings when necessary. These representatives raise issues of concern to their constituencies and obtain information about the MHT program to share with their staff and beneficiaries.

#### *Physician Assured Access System (PAAS)*

The program was created in 1992 and has been operated by the Bureau for Medical Services since that time. This includes the needed coordination, monitoring, and oversight functions that help guarantee access, quality, and cost-effectiveness of the program. The program enrolled 3,770 individuals as of December 2013.

The PAAS program has improved access to care and promoted a medical home concept by providing a primary care provider responsible for care in the communities where enrollees live.

**A. Statutory Authority**

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

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

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

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

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

- a. \_\_\_ **Section 1902(a)(1) - Statewideness**--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. X **Section 1902(a)(10)(B) - Comparability of Services**--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
- c. X **Section 1902(a)(23) - Freedom of Choice**--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d. \_\_\_ **Section 1902(a)(4) - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).**
- e. \_\_\_ **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. X **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. \_\_\_ **PIHP**: Prepaid Inpatient Health Plan means an entity that:
  - (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.



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

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

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

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

e.  **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:  
 the same as stipulated in the state plan  
 is different than stipulated in the state plan (please describe)

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

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

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

With the exception of rural areas authorized under the rural exception as detailed below, beneficiaries have a choice between MCOs or an MCO and PCCM.

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

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

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- \_\_\_ Two or more PIHPs.
- \_\_\_ Two or more PAHPs.
- \_\_\_ Other: (please describe) – One plan under rural exception

The ultimate goal of the Bureau remains to provide enrollees with a choice of more than one MCO in every county, and the State will continue efforts to recruit health plans and encourage a competitive, two-plan (at a minimum) model in every county.

### 3. **Rural Exception**.

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

The Bureau is no longer seeking a rural exception as there will be two or more MCOs operating in all rural counties in the state. Sixteen counties – Braxton, Calhoun, Grant, Greenbrier, Hardy, Mason, McDowell, Mercer, Monroe, Nicholas, Pendleton, Pocahontas, Roane, Summers, Webster and Wyoming – were previously approved by CMS for the rural option. Seven of these (Grant, Hardy, Mason, McDowell, Nicholas, Pendleton and Summers) have since converted to the two-plan MCO model and nine of these (Braxton, Calhoun, Greenbrier, Mercer, Monroe, Pocahontas, Roane, Webster and Wyoming) have converted to the three-plan MCO model.

The following table lists the 34 counties that meet the definition of “rural” and the current type of program in each county.

<b>County</b>	<b>Qualifies as “rural”</b>	<b>Network currently approved by CMS for one plan enrollment</b>
Barbour	Yes	Not needed (multiple MCOs)
Braxton	Yes	Not needed (multiple MCOs)
Calhoun	Yes	Not needed (multiple MCOs)
Doddridge	Yes	Not needed (multiple MCOs)
Fayette	Yes	Not needed (multiple MCOs)
Gilmer	Yes	Not needed (multiple MCOs)
Grant	Yes	Not needed (multiple MCOs)
Greenbrier	Yes	Not needed (multiple MCOs)
Hardy	Yes	Not needed (multiple MCOs)
Harrison	Yes	Not needed (multiple MCOs)
Jackson	Yes	Not needed (multiple MCOs)
Lewis	Yes	Not needed (multiple MCOs)
Logan	Yes	Not needed (multiple MCOs)
Marion	Yes	Not needed (multiple MCOs)
Mason	Yes	Not needed (multiple MCOs)
McDowell	Yes	Not needed (multiple MCOs)
Mercer	Yes	Not needed (multiple MCOs)
Mingo	Yes	Not needed (multiple MCOs)
Monroe	Yes	Not needed (multiple MCOs)
Nicholas	Yes	Not needed (multiple MCOs)
Pendleton	Yes	Not needed (multiple MCOs)
Pocahontas	Yes	Not needed (multiple MCOs)
Raleigh	Yes	Not needed (multiple MCOs)
Randolph	Yes	Not needed (multiple MCOs)
Ritchie	Yes	Not needed (multiple MCOs)
Roane	Yes	Not needed (multiple MCOs)
Summers	Yes	Not needed (multiple MCOs)
Taylor	Yes	Not needed (multiple MCOs)
Tucker	Yes	Not needed (multiple MCOs)
Tyler	Yes	Not needed (multiple MCOs)
Upshur	Yes	Not needed (multiple MCOs)
Webster	Yes	Not needed (multiple MCOs)
Wetzel	Yes	Not needed (multiple MCOs)
Wyoming	Yes	Not needed (multiple MCOs)

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

- Beneficiaries will be limited to a single provider in their service area (please define service area).  
 Beneficiaries will be given a choice of providers in their service area.

**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)
Barbour	MCO four plan	Coventry, The Health Plan (THP), UniCare of WV (UniCare), West Virginia Family Health (WVFH)
Berkeley	MCO three plan	Coventry, UniCare, WVFH
Boone	MCO four plan	Coventry, THP, UniCare, WVFH
Braxton	MCO four plan	Coventry, THP, UniCare, WVFH
Brooke	MCO four plan	Coventry, THP, UniCare, WVFH
Cabell	MCO/PCCM	Coventry, PAAS
Calhoun	MCO four plan	Coventry, THP, UniCare, WVFH
Clay	MCO four plan	Coventry, THP, UniCare, WVFH
Doddridge	MCO four plan	Coventry, THP, UniCare, WVFH
Fayette	MCO four plan	Coventry, THP, UniCare, WVFH
Gilmer	MCO four plan	Coventry, THP, UniCare, WVFH
Grant	MCO four plan	Coventry, THP, UniCare, WVFH
Greenbrier	MCO four plan	Coventry, THP, UniCare, WVFH

<b>City/County/Region</b>	<b>Type of Program (PCCM, MCO, PIHP, or PAHP)</b>	<b>Name of Entity (for MCO, PIHP, PAHP)</b>
Hampshire	MCO four plan	Coventry, THP, UniCare, WVFH
Hancock	MCO four plan	Coventry, THP, UniCare, WVFH
Hardy	MCO four plan	Coventry, THP, UniCare, WVFH
Harrison	MCO four plan	Coventry, THP, UniCare, WVFH
Jackson	MCO four plan	Coventry, THP, UniCare, WVFH
Jefferson	MCO four plan	Coventry, THP, UniCare, WVFH
Kanawha	MCO four plan	Coventry, THP, UniCare, WVFH
Lewis	MCO four plan	Coventry, THP, UniCare, WVFH
Lincoln	MCO four plan	Coventry, THP, UniCare, WVFH
Logan	MCO four plan	Coventry, THP, UniCare, WVFH
Marion	MCO four plan	Coventry, THP, UniCare, WVFH
Marshall	MCO four plan	Coventry, THP, UniCare, WVFH
Mason	MCO four plan	Coventry, THP, UniCare, WVFH
McDowell	MCO three plan	Coventry, UniCare, WVFH
Mercer	MCO four plan	Coventry, THP, UniCare, WVFH
Mineral	MCO four plan	Coventry, THP, UniCare, WVFH
Mingo	MCO four plan	Coventry, THP, UniCare, WVFH
Monongalia	MCO four plan	Coventry, THP, UniCare, WVFH
Monroe	MCO four plan	Coventry, THP, UniCare, WVFH
Morgan	MCO four plan	Coventry, THP, UniCare, WVFH
Nicholas	MCO four plan	Coventry, THP, UniCare, WVFH
Ohio	MCO four plan	Coventry, THP, UniCare, WVFH
Pendleton	MCO four plan	Coventry, THP, UniCare, WVFH
Pleasants	MCO four plan	Coventry, THP, UniCare, WVFH

<b>City/County/Region</b>	<b>Type of Program (PCCM, MCO, PIHP, or PAHP)</b>	<b>Name of Entity (for MCO, PIHP, PAHP)</b>
Pocahontas	MCO four plan	Coventry, THP, UniCare, WVFH
Preston	MCO four plan	Coventry, THP, UniCare, WVFH
Putnam	MCO four plan	Coventry, THP, UniCare, WVFH
Raleigh	MCO four plan	Coventry, THP, UniCare, WVFH
Randolph	MCO four plan	Coventry, THP, UniCare, WVFH
Ritchie	MCO four plan	Coventry, THP, UniCare, WVFH
Roane	MCO four plan	Coventry, THP, UniCare, WVFH
Summers	MCO four plan	Coventry, THP, UniCare, WVFH
Taylor	MCO four plan	Coventry, THP, UniCare, WVFH
Tucker	MCO four plan	Coventry, THP, UniCare, WVFH
Tyler	MCO four plan	Coventry, THP, UniCare, WVFH
Upshur	MCO four plan	Coventry, THP, UniCare, WVFH
Wayne	MCO/PCCM	Coventry, PAAS
Webster	MCO four plan	Coventry, THP, UniCare, WVFH
Wetzel	MCO four plan	Coventry, THP, UniCare, WVFH
Wirt	MCO four plan	Coventry, THP, UniCare, WVFH
Wood	MCO four plan	Coventry, THP, UniCare, WVFH
Wyoming	MCO four plan	Coventry, THP, UniCare, WVFH

## 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  
 Voluntary enrollment

Mandatory enrollment of all TANF and TANF-related children, medically needy individuals with income greater than the categorically needy threshold, but below the medically needy spenddown threshold (i.e., medically needy with \$0 spenddown), and children with special health care needs who are enrolled in the State's Children with Special Health Care Needs program and receive services from the State, which are funded by Title V grants.

**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

Mandatory enrollment of TANF and TANF-related adults, pregnant women and medically needy individuals with income greater than the categorically needy threshold, but below the medically needy spenddown threshold (i.e., medically needy with \$0 spenddown).

**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

Mandatory enrollment of this population (excluding dual eligibles and those in residential settings and MR/DD waivers) in the current waiver program has been approved by CMS. The State has

not yet initiated enrollment of this population, but will do so during the coming waiver period. A phase-in schedule for this population is currently under development. The State will submit the draft phase-in schedule for enrollment of this population for CMS review and approval. Individuals in the aged/disabled waiver are excluded from 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

Mandatory enrollment of this population (excluding dual eligibles and those in residential settings and MR/DD waivers) in the current waiver program has been approved by CMS. The State has not yet initiated enrollment of this population, but will do so during the coming waiver period. A phase-in schedule for this population is currently under development. The State will submit the draft phase-in schedule for enrollment of this population for CMS review and approval. Individuals in the aged/disabled waiver are excluded from enrollment.

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

- Mandatory enrollment
- Voluntary enrollment

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

- Mandatory enrollment
- Voluntary enrollment

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

- Mandatory enrollment
- Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the



“Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

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

**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.

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

**Other** (Please define):

Medically needy individuals with incomes at or above the spenddown threshold are excluded from participation in the waiver programs.

## F. Services

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

### 1. Assurances.

- X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
  - Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
  - Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b).

\_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or 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).

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

\_\_\_\_\_ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services

will be available in the same amount, duration, and scope as they are under the State Plan.

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

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

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

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

\_\_\_ 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:

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

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

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

\_\_\_ Other (please explain):

\_\_\_ Family planning services are not included under the waiver.

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

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

Each MCO must contract with FQHCs such that enrollees who choose an FQHC-based provider as their PCP can do so within the PCP time and distance standards (i.e., 30-minute travel time standard). The MCO must contract with as many FQHCs as necessary to permit beneficiary access to participating FQHCs without having to travel a significantly greater distance past a non-participating FQHC. An MCO with an FQHC on its panel that has no capacity to accept new patients will not satisfy these requirements. If an MCO cannot satisfy the standard for FQHC access at any time while the MCO holds a Medicaid contract, the MCO must allow its Medicaid members to seek care from non-contracting FQHCs and must reimburse these providers at Medicaid fees.

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

5. **EPSDT Requirements.**

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

## 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.

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

### *In MCOs*

- Following implementation of new benefits or populations in the managed care benefit package, self-referral to a provider for up to 90 days if the provider is not part of the network but is the main source of care and is given the opportunity to join the network but declines.
- MCO/PIHP/PAHP/PCCM or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.
- Each MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a primary care physician for routine services. West Virginia insurance regulations also require MCOs to allow women direct access to a women's health specialist.

### *In PCCM*

- Self-referral to WV Medicaid participating providers is allowed for most Medicaid-covered vision services, hearing, dental, behavioral health, and OB/GYN services.

## Part II: Access

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

### A. Timely Access Standards

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

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

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

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

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

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

a. X **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. X PCPs (please describe): 30 minutes, 30 miles, or community standard

2. X Specialists (please describe): 30 minutes or community standard

3.  Ancillary providers (please describe):
4.  Dental (please describe):
5.  Hospitals (please describe):
6.  Mental Health (please describe):
7.  Pharmacies (please describe): 30 minutes or community standard
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):

The PCCM Provider Agreement requires that providers make:

- An evaluation of a member or refer the member for an evaluation within 24 hours for those members with an urgent medical condition; and
- Treatment for non-urgent issues (excluding routine physical exams) must be available within 3 weeks. Patients may be authorized to see another provider if office appointments are unavailable.

The PCCM PCP may authorize the PCCM patient to see another primary care provider or urgent care facility provider if an acute care visit is requested at a time when no office appointments are available.

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. X Urgent care (please describe): provide or refer for evaluation within 24 hours

8. \_\_\_ Other providers (please describe):

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

1. \_\_\_ PCPs (please describe):

2. \_\_\_ Specialists (please describe):

3. \_\_\_ Ancillary providers (please describe):

4. \_\_\_ Dental (please describe):

5. \_\_\_ Mental Health (please describe):

6. \_\_\_ Substance Abuse Treatment Providers (please describe):

7. \_\_\_ Other providers (please describe):

d. \_\_\_ **Other Access Standards** (please describe)

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

## **B. Capacity Standards**

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

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

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



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

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

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

- a. X The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

PCCM Providers may specify a limit to the number of Medicaid members he/she is willing to accept into his/her practice, and agrees to accept enrollees in the order in which they apply without restriction, not to exceed 2,000 per PCP Full-time Equivalent (FTE) or the limits established by the provider if less than 2,000.

- b. X The State ensures that there are adequate numbers of PCCM PCPs with **open panels**. Please describe the State's standard.

The State monitors and reviews complaints and grievances to identify access issues, and results of the bi-annual member satisfaction survey. The State's enrollment broker also verifies that members selecting a PCP or being assigned a PCP meet the panel restrictions and that the PCP's panel status is appropriate (e.g., accepting new patients).

- c. X The State ensures that there is an **adequate number** of PCCM PCPs under the waiver to assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

Capacity is monitored through measurement of enrollee requests for disenrollment from a PCCM due to capacity issues, and tracking of complaints/grievances concerning capacity issues. In the last waiver period, as the MCO program has grown and expanded across the State, PCCM enrollment continued to decline in this waiver period as the MCO program expanded across the State, so capacity has not been a concern.

- 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.
- e.  The State ensures adequate **geographic distribution** of PCCMs. Please describe the State’s standard.

The State uses the following standards: provider member ratios and PCPs with open panels. The State has established a maximum provider to member ratio of 1:2,000 for each county. In addition, the State tracks monthly provider enrollments and terminations, as well as information and formal enrollee complaints regarding provider access and availability.

- 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.

The PCCM program only operates in two counties, Cabell and Wayne. PCP to enrollee ratios for both of these counties is provided in the table below.

Area(City/County/Region)	PCCM-to-Enrollee Ratio
Cabell	1:24
Wayne	1:129
<b>Statewide Average</b>	<b>1:36</b>

\* Ratios are based on counts of unique PAAS providers enrolled in the county and unique PCCM enrollees in the county as of December 2013.

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

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

### C. Coordination and Continuity of Care Standards

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

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

The following items are required.

- a. \_\_\_ 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. X **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.

The State has two mechanisms to identify persons with special health care needs to MCOs. First, individuals are identified by the enrollment broker during the health assessments conducted as part of the enrollment process. Enrollment counselors review all health assessment forms and record any information on medical conditions, physician preferences, or potential health problems in a comment field on the enrollment screen. Counselors conducting enrollment over the telephone also record any health assessment information in this field. This data, along with copies of the health assessment forms, is forwarded to MCOs with the enrollment rosters sent by the State's fiscal agent. In addition, the Office of Maternal and Child sends the Bureau for Medical Services a list of the children enrolled in the State's Children with Special Health Care Needs Program on a monthly basis. The Bureau reviews the list to identify children

enrolled in an MCO and includes this information on the enrollment rosters sent by the State's fiscal agent.

- c. X **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.

The MCO must ensure that an initial assessment of each enrollee's health care needs is completed within 90 days of the effective date of enrollment.

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

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

- e. X **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. X Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. X 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. X Each enrollee receives **health education/promotion** information. Please explain.

EPSDT-eligible enrollees receive materials describing the EPSDT program and how to access these services. These materials include an initial introduction letter, a fact sheet, and brochure with information about the program. An outreach worker contact enrollees who have not utilized EPSDT services to ensure they are informed about the program.

- d. X Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. X There is appropriate and confidential **exchange of information** among providers.
- f. X Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. X 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. X **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.

Referral may be in writing or received over the phone. Referrals for specialty care must be made by the PCCM PCP. A PAAS Referral Form is required to document appropriate referral for care and ancillary services. Referrals received over the phone must be documented in the provider's chart. Referrals to specialty physicians may also be utilized to obtain consultative opinions from a physician whose advice is requested by the PCP for further evaluation or management of the patient. A consultant is not expected to follow-up or see the patient again unless requested by the PCP.

The duration of the treatment is specified on the Referral Form, which are not valid for longer than 180 days. The duration may be expressed as a number of office visit or start/end dates.

When referring an enrollee to a specialist, the PCP must provide a Referral Form identifying his/her PCCM Provider Number to allow the specialist to

bill for services. The PCP's PCCM Provider Number must be included on all electronic and paper claims.

The PCP and the specialist must each keep a copy of the completed Referral Form in the enrollee's medical record. Medical records will be subject to audit by DHHR.

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.

**Part III: Quality**

1. **Assurances for MCO or PIHP programs.**

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Delmarva Foundation for Medical Care, Inc.	Systems Performance Review	X	
		Performance Improvement Project Review	X	
		Performance Measure Validation	X	
		Focused Studies		
PIHP	N/A			

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© (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. X **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. X Provide education and informal mailings to beneficiaries and PCCMs;
  2. X Initiate telephone and/or mail inquiries and follow-up;
  3. X Request PCCM's response to identified problems;
  4. X 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): Reduce or withhold management fees.

- 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. X 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. X Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. X 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:

## Part IV: Program Operations

### A. Marketing

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

#### 1. Assurances

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

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

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

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

#### 2. Details

##### a. **Scope of Marketing**

1. \_\_\_\_\_ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

The State allows MCOs to conduct the following marketing activities without State approval:

- General, non-Medicaid advertising
- Enrollee-initiated requests for phone conversations with plan staff

The State may allow MCOs to conduct the following marketing activities with State pre-approval:

- General, Medicaid-specific advertising,
- Mailings in response to enrollee requests, and
- Gifts to enrollees based on specific health events unrelated to enrollment (e.g., baby T-shirt showing immunization schedule).

3. X 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.

Regarding the PCCM program, the State permits direct marketing from PCPs to established patients concerning selection of a PCCM PCP. The PCCM program does not supply PCPs with mailing lists of potential enrollees. All other forms of direct marketing to PCCM eligible individuals is prohibited.

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

1. X 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.

The use of gifts or other incentives to entice potential enrollees is strictly prohibited. After enrollment, pertinent items (e.g., magnet with immunization schedule) up to \$25 MAY be approved by the State, but MUST be pre-approved. MCOs may only issue gift cards to members in connection with their participation in MCO initiatives in the areas of health education or improved medical outcomes (e.g., reward for participation in MCO prenatal program) unrelated to enrollment. The value of each gift card may not exceed \$25 and gift cards may not exceed \$100 in fair-market value per enrollee over a twelve-month period. The gift cards may not be converted to cash.

The State will continue to monitor marketing activities during the upcoming waiver period by reviewing marketing materials prior to distribution, monitoring enrollee complaints and grievances on a quarterly basis, and monitoring disenrollment reasons on a monthly basis. The State will also provide MCOs and PCCMs with assistance to develop appropriate materials upon request.

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.

The State considers any language spoken by 5% or more of the population to be significant; currently no language other than English is spoken by more than 1% of the population. On an ongoing basis, the State reviews reports generated from the eligibility system, which records demographic information such as primary language at the time of the application, to determine prevalent languages.

- iii. \_\_\_ Other (please explain):

## **B. Information to Potential Enrollees and Enrollees**

### **1. Assurances.**

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

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

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

the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

## 2. Details.

### a. **Non-English Languages**

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 does not require translation of enrollee materials into any other languages as English is the primary language spoken (99.9%). However, the State's enrollment broker provides makes available translated copies of enrollment fact sheets. Fact sheets are available in French, Italian, Russian, Spanish, and Vietnamese.

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.  Other (please explain):

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

The enrollment broker, which performs PCCM and MCO enrollment, and MCOs contract with a translation service (AT&T Language Line) that can provide real-time translation in a three-way call so that persons who do not speak English can ask questions and complete the enrollment process over the phone.

The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The State has an outreach process to ensure that information is available. To facilitate understanding of managed care, the enrollment broker subscribes to a language translation service. Also, the Guide to Medicaid is available to all

enrollees and potential enrollees at the local DHHR offices. The Guide to Medicaid can be accessed at <http://www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf>.

## b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify): Automated Health Systems (AHSI) is the state's contracted Enrollment Broker organization.

All enrollees or potential enrollees are provided information about the managed care programs and options at the DHHR office through the Guide to Medicaid. The enrollment broker provides additional information specific to the PCCM and MCO programs. The Guide to Medicaid can be accessed at <http://www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf>.

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

## c. Enrollee Information

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

- (i)  the State
- (ii)  State contractor (please specify): Automated Health Systems (AHSI) is the State's contracted Enrollment Broker organization.
- (ii)  the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

## C. Enrollment and Disenrollment

### 1. Assurances.

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

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

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

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

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

a. X **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

When enrollment in a new county is planned, the State notifies the enrollment broker, Automated Health Systems, Inc. (AHSI), and eligible persons in that county are added to the enrollment broker's mailing list. The enrollment broker provides outreach and education to potential enrollees, and is also responsible for making outreach calls to potential enrollees with valid telephone numbers. The enrollment broker has two units: the telephone unit, which staffs the toll-free telephone line, and field staff, who travel around the state.

Outreach is a key component of the enrollment process. In addition to the mailings that are distributed to potential enrollees, enrollment broker staff attempts to call every potential enrollee. As the end of the choice period approaches, enrollment broker staff makes a second attempt to contact new enrollees who have not chosen an MCO or PCCM provider, to avoid auto-assigning the beneficiaries. For potential enrollees without valid telephone numbers, the enrollment broker makes an effort to reach as many people as possible through outreach efforts made in the community.

When there are program changes related to Mountain Health Trust or the PAAS program local DHHR offices are contacted by the Outreach and Education Specialist (OES) to provide relevant updates and trainings. In-service trainings are scheduled with DHHR staff as needed. In an effort to connect with Medicaid members directly, field staff often set up an informational table in the DHHR lobby, especially in the case of changes to MCO availability within a particular county. Local DHHR office staff will also provide the beneficiary a brochure and/or the 1-800 number for referral. DHHR offices can also contact the OES to request meetings with individuals or to advise of any issues or questions.



Enrollment broker staff attends meetings with key players in the community, including agencies working directly with potential enrollees, to help spread the word to enrollees about MHT and PAAS. At these meetings, enrollment broker staff coordinate with these agencies to devise direct outreach opportunities to the Medicaid population, such as immunization clinics, Head Start parents meetings, preschool screenings, Adult Education Programs, WIC clinics, Health Departments and Health Fairs among others. Enrollment broker staff also conduct outreach and educational sessions for any agency interested in learning more about MHT or PAAS.

The enrollment broker's OES also utilize other venues such as libraries, food pantries, clothing closets, laundromats, and grocery stores, to display information on the MHT and PAAS programs. Other opportunities, especially around the holidays, arise when community organizations give out food baskets, Christmas toys, and clothing vouchers. Enrollment broker staff attend these events to answer questions on how to enroll by telephone, mail, or the web.

The enrollment broker makes presentations at conferences and organizational meetings in the communities to make citizens aware of the project and encourage them to help advertise the program. Enrollment broker staff attend all provider forums held by the state, distributing brochures, handouts, 1-800 cards, posters, videos and answering questions about community outreach and the enrollment process.

The AHS Helpline Information Specialists are available for traditional phone enrollments and enrollment counseling Monday through Friday from 8:00 a.m. to 8:00 p.m. After hours, the caller is requested to leave a message and the call is returned on the next business day.

The enrollment broker also offers secure web based online enrollment for potential enrollees interested in 24/7 self-service options through the MountainHealthTrust.com website. Enrollees can use the provider search feature on the website to locate PCPs and/or specialists to ensure continuity of care. The website also offers links to project materials, provides answers to frequently asked questions, and uses positive language to promote active choice. The website also reaches out to enrollees with special needs by letting users know that assistance in other languages, Braille, and audiotape are available free of charge.

OESs visit Medicaid providers on a frequent basis to educate them regarding the enrollment process for their patients, inform them of any updates, answer questions, provide outreach materials, and follow up, as needed. AHS has identified that provider offices are a key outreach location, as they can direct their patients who have not yet chosen a MCO or PCCM to contact AHS for enrollment or MCO or PCCM provider changes, if necessary. OESs leave MHT/PAAS program brochures and a supply of business-size cards with the AHS toll-free helpline number as handouts for their patients.

The individual MCOs educate the community providers on their role in the MHT program and the enrollment broker conducts educational sessions on the enrollment process for providers and distributes literature to providers about the MHT program. The enrollment broker also provides in-service trainings for MCO member services staff to help them understand the enrollment broker's role in outreach and enrollment and to learn more about community resources.

**b. Administration of Enrollment Process.**

State staff conducts the enrollment process.

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

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

Broker name: Automated Health Systems, Inc. (AHSI)

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

The enrollment broker is responsible for the following functions:

- Conducting outreach and enrollment for the MCO program and PCCM (please see our response above for a description of the outreach process and the additional information included under Enrollment and Disenrollment).
- Conducting an initial health assessment screen for all new enrollees and transmitting the information to the MCOs and other appropriate parties.
- Processing requests for plan or provider changes.
- Receiving and responding to beneficiary complaints and grievances related to the enrollment process.
- Training county eligibility workers about the program.
- Meeting with community stakeholders and providing education about the program.
- Tracking and reporting on enrollment and disenrollment and complaint and grievance data.
- Participating in Mountain Health Trust Task Force meetings with the State and MCOs, and Medical Services Fund Advisory

Council meetings.

- Providing general outreach to beneficiaries, providers, MCO staff, state agencies, and communities about the program's status, new initiatives, etc.

     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.):

  X 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.)

In the coming waiver period, the State will begin transitioning eligible SSI beneficiaries into MCOs. BMS anticipates enrollment will initiate in the more populous counties of the State (i.e., the areas surrounding Morgantown, Parkersburg, and Wheeling). BMS will provide an implementation plan and phase-in schedule for enrollment of the SSI population once a transition date is confirmed. The State will submit outreach materials and network documentation prior to SSI implementation in a county.

  X 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.   X Potential enrollees will have 30-45 days/month(s) to choose a plan.

ii.   X 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.

Regarding the general enrollment and disenrollment process, the State notifies the enrollment broker, Automated Health Systems, Inc., of persons eligible for MHT and PAAS through a weekly file transfer. AHS uses the file to create the enrollment packet mailings that are sent to enrollees approximately 30-45 days prior to their enrollment deadline. The enrollment packet includes a welcome letter, a summary brochure of MHT and PAAS programs, a preprinted enrollment form, a single-page summary of each plan

(for MHT only), an MCO Plan Comparison chart, a checklist of the steps to complete the enrollment process, and a self-addressed stamped envelope for the enrollee to return the enrollment form to the enrollment broker. Enrollees also receive a health risk assessment form that requests information on the beneficiaries' health status and needs. Beneficiaries can call the toll-free number or mail the enrollment form to enroll. The printed materials also include information on the Mountain Health Trust website that enrollees can access for more information, search for providers, and enroll online.

The enrollment broker attempts to call each beneficiary two weeks prior to automatic assignment if the beneficiary has not made a choice by that time. All the materials the enrollment broker sends to beneficiaries are written on a sixth grade reading level. The enrollment information is also available on audiotape for those who cannot read, and the tape refers them to call the enrollment broker's 1-800 number to enroll. The enrollment broker also provides fact sheets that explain the enrollment process to agencies that work with non-English speaking clients. These fact sheets can be translated into any language, and the field staff alert agencies of the availability of this service.

If the beneficiary does not return the enrollment form within 14 days, the enrollment broker sends a reminder letter to the beneficiary to again encourage the beneficiary to voluntarily choose an MCO or PCCM. At approximately the 10<sup>th</sup> of the month, AHS sends an auto-assignment file to the fiscal agent after assigning the members who have not made a choice to a plan using the auto-assignment algorithm described in this waiver. These assignments are scheduled to become effective the 1<sup>st</sup> of the following month. Simultaneously, the enrollment broker uses an automatic dialing campaign to contact the enrollees scheduled for auto-assignment to encourage active choice prior to cutoff. Members who contact the helpline and choose their MCO in response to the outreach campaign have their enrollment changed from auto-assignment to choice in the fiscal agent's system. After cutoff, the state's fiscal agent reconciles the enrollment information with the updated enrollment broker data.

The auto-assignment process does not include enrollees who had previously chosen or were enrolled in an MCO within the last year and who lost and then regained eligibility. The fiscal agent automatically assigns the enrollee back to the plan he/she was previously enrolled once they are determined eligible. These members do not appear on the weekly eligibility file. \_

*MCO Program*

Non-choosers are evenly split across the MCOs in the county. The algorithm is designed to assign different members of the same family to the same MCO. If there is only one MCO in the county (e.g., MCO/PCCM county), non-choosers are auto-assigned to the MCO. Beneficiaries, including persons with special health care needs, who lose and regain eligibility for enrollment in Mountain Health Trust within one year are auto-assigned to their previous MCO or PCCM provider. If the person has been disenrolled for more than one year, the enrollment broker will follow the customary auto-assignment algorithm.

All program MCOs are required to serve the needs of persons with special health care needs so there is no need to modify the auto-assignment process. Any person who is auto-assigned can change PCPs or between the managed care entities in their county at any time.

*PCCM*

If there is no response from the consumer to the enrollment mailing, then the consumer is automatically assigned, enrollees are assigned to the MCO.

- The State **automatically enrolls** beneficiaries
  - on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
  - on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
  - on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:  
  
In non-rural areas, beneficiaries have a choice of multiple MCOs or an MCO or the PAAS program. The State automatically enrolls beneficiaries (if they do not make a choice) into an MCO in counties where the MCO and PAAS program operate.
- The State provides **guaranteed eligibility** of \_\_\_ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

All West Virginia Medicaid beneficiaries who are children (aged 0-19 years) are granted 12 months *continuous* Medicaid eligibility.

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.

Beneficiaries, including persons with special health care needs, who lose and regain eligibility for enrollment in Mountain Health Trust within one year are auto-assigned to their previous MCO or PCCM provider. If the person has been disenrolled for more than one year, the enrollment broker will follow the customary auto-assignment algorithm.

**d. Disenrollment:**

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

i.  Enrollee submits request to State.

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

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

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

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

X 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.

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

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

*MCO Program*

The MCO may not involuntarily disenroll any member except as specified below:

- Loss of eligibility for Medicaid or for participation in Medicaid managed care, including becoming a Medicare beneficiary.
- Failure of the State to make a premium payment on behalf of a member (West Virginia insurance regulations require that MCOs be permitted to disenroll a member if the payer fails to make premium payments for that member).
- The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must immediately re-enroll into a new MCO or PCCM, depending on the county.
- Continuous placement in a nursing facility, State institution or intermediate care facility for the mentally retarded for more than 30 days.
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for exemption is approved if the enrollment broker enrolled the beneficiary while their exemption request was being considered.
- Upon the beneficiary's death.

The MCO may not terminate enrollment because of an adverse change in the enrollee's health status; the enrollee's utilization of medical services; diminished mental capacity; or uncooperative or disruptive behavior resulting from his

or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this or other enrollees). The MCO must assure BMS that terminations are consistent with the reasons permitted under the contract. The State has responsibility for promptly arranging for services for any recipient whose enrollment is terminated for reasons other than loss of Medicaid eligibility.

*PCCM Program*

The primary care case manager can request reassignment of an enrollee for the following reasons:

- Specialists who serve as PCPs and change their focus of practice;
- PCPs who must reduce patient maximums (usually accomplished through attrition);
- PCPs that are not accepting new patients and have been assigned a member without their consent;
- Enrollees assigned to a PCP's practice in error;
- Assignments made that do not agree with the age range limitations of the practice;
- Members who are Medicare beneficiaries;
- Members who are in a long term care institution;
- Patients who are noncompliant;
- Enrollees who repeatedly do not keep appointments;
- Enrollees who have been discharged from the practice because of abusive, uncooperative, or disruptive behavior unrelated to diminished mental capacity resulting from a special need; or
- Continued enrollment impairs the provider's ability to furnish services.

The policy includes, but is not limited to, disharmonious relationships due to differences in philosophies, expectations, or behavior patterns between the provider and the patient, parent, or guardian.

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

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

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

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

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

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

## E. Grievance System

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

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

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

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

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

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

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

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

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

X 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**

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

c. **Special Needs**

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

The State provides assistance for persons with special needs who need help filing a request. This can be conducted orally; in addition, providers or enrollment representatives can assist the enrollee with filing the request.

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 procedure 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.

In the case where the timeframe for a standard resolution of appeals could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function, the timeframe is \_\_\_\_\_

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

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

\_\_\_ Other (please explain):

## F. Program Integrity

### 1. Assurances.

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

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

The prohibited relationships are:

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

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

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

### 2. Assurances For MCO or PIHP programs

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

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

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

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

## **Part 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.



*MCO and PCCM Programs*

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												MCO
Consumer Self-Report data	MCO PCCM	MCO			MCO PCCM		MCO PCCM	MCO PCCM	MCO	MCO	MCO PCCM	
Data Analysis (non-claims)	MCO PCCM	MCO PCCM	MCO PCCM	MCO PCCM		MCO PCCM	MCO PCCM	MCO PCCM		MCO PCCM	MCO PCCM	MCO PCCM
Enrollee Hotlines	MCO PCCM	MCO PCCM	MCO PCCM									PCCM
Focused Studies												
Geographic mapping								MCO				
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan			MCO PCCM					MCO			MCO	
Ombudsman												
On-Site Review				MCO	MCO	MCO	MCO	MCO	MCO	MCO		MCO

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Performance Improvement Projects									MCO	MCO		MCO
Performance Measures			MCO PCCM			MCO	MCO PCCM	MCO PCCM		MCO PCCM		MCO PCCM
Periodic Comparison of # of Providers								MCO PCCM			MCO	
Profile Utilization by Provider Caseload								MCO				
Provider Self-Report Data												
Test 24/7 PCP Availability							MCO					MCO
Utilization Review				MCO PCCM			MCO PCCM		MCO PCCM	MCO		MCO PCCM
Other: (describe)												

## Part II. Details of Monitoring Activities

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

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

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

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

- NCQA  
 JCAHO  
 AAAHC  
 Other (please describe)

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

- NCQA  
 JCAHO  
 AAAHC  
 Other (please describe)

MCOs are required to keep current accreditation from NCQA for their Medicaid lines of business. Any new MCO entering must apply for accreditation with NCQA no later than nine months from its operational start date in West Virginia. MCOs submit their accreditation status reports to BMS for review.

- c.  Consumer Self-Report data

- CAHPS (please identify which one(s))  
 State-developed survey  
 Disenrollment survey  
 Consumer/beneficiary focus groups

MCOs are required to conduct annual member satisfaction surveys, the results of which are reviewed by the State and the external quality review organization. The MCOs use the Consumer Assessment of Health Plans Survey (CAHPS) for adults and children and contain questions regarding choices of PCPs, availability of routine, urgent, and emergency appointments, distance to PCP offices, availability of PCPs after-hours, referrals to specialists, ability to access specialty services, and enrollee knowledge about how to obtain health care services.

All disenrollments are processed by the State’s enrollment broker. At the time of disenrollment, enrollment broker staff collect information on the reasons for the change from MCO and PCCM beneficiaries and monitor this data regularly.

- d. X Data Analysis (non-claims)
- Denials of referral requests
  - X Disenrollment requests by enrollee
    - From plan
    - X From PCP within plan (PCCM)
    - X Grievances and appeals data
  - X PCP termination rates and reasons
  - X Other (please describe) – Periodic MCO reporting

*Disenrollment Requests*

All enrollments and disenrollments are processed by the State’s enrollment broker. Information on the reasons for MCO and PCCM changes are recorded monthly and are monitored by the enrollment broker and the State. The enrollment broker produces monthly reports that track all enrollment changes which are provided to the Director of Managed Care. The broker tracks all requests for enrollment and categorizes them as follows:

- Not satisfied with auto-assigned MCO
- Doctor recommended
- Provider not in plan
- Not satisfied with doctor
- Not satisfied with the MCO
- Not satisfied with hospital
- Managed care county (county changed from a PAAS-only to a managed care county)
- Written enrollment (enrollee changed MCO or PCP through a written enrollment instead of a phone call)
- Other

The State reviews the reasons for disenrollment to determine if there are any underlying problems with access or quality of care. If trend analysis

proves that there are issues pertaining to quality, access, or other related topics, a specific provider corrective action is requested of the provider. The findings are also discussed at the Mountain Health Trust Task Force meetings.

#### *Grievances and Appeals*

All formal and informal grievances received by the MCOs are categorized into one of four areas – service denied, payment complaint, service complaint, or quality of care. The MCOs also report the number of appeals. A summary of these grievances and appeals is provided to the State on a quarterly basis. In addition, the MCOs also separately track and report on grievances and appeals filed for pharmacy services or filed by or on behalf of children with special health care needs (CSHCN). The MCOs will also be required to track and report grievances filed by SSI enrollees after program expansion.

PCCM members have the right to a State Fair Hearing.

#### *PCP Termination Rates and Reasons*

MCOs are required to submit quarterly reports with a list of their PCP providers and panel sizes, and any additions or terminations. After enrollment of SSI enrollees in the upcoming waiver period, MCOs will submit similar reports for providers serving SSI enrollees. The MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions within 14 days.

#### *Periodic MCO Reporting*

WV MCOs are required to provide the State with periodic reports on a variety of performance areas, including administrative, financial, utilization, quality and satisfaction, member and provider services functions, and encounter data. The State reviews these reports to monitor quality, access, and performance on an ongoing basis. Some of the specific reporting requirements for these sections are provided below.

#### **Provider network**

Each quarter, MCOs must submit a list of all PCPs with each PCP's panel size at the beginning and end of the quarter, the number of providers with open and closed panels, and the date of any PCP additions or terminations from the network. The MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions within 14 days. The MCOs report any disenrollment of hospitals from the MCO's network to BMS immediately.

The MCOs also submit information on network changes quarterly. The MCOs submit full network documentation at least annually, which includes the name, address, specialty, identification numbers, and

restrictions (e.g., not accepting new patients, age) for all primary, specialty, ancillary, and facility providers in the MCOs' networks.

**Financial data**

Annually, on or before March 1<sup>st</sup>, each MCO must submit audited financial statements for the previous year. Each MCO must also submit copies of its quarterly and annual Department of Insurance reports, as well as any revisions thereto. Each MCO must include reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the Department of Insurance.

On a quarterly basis, each MCO must submit Medicaid-specific financial statements and information on third party liability collections. MCOs are also required to submit a summary of any claims paid outside of the encounter data and sub-capitation arrangements.

**Utilization**

MCOs must submit utilization information separately for TANF and SSI enrollees to the State quarterly in standard format, including:

- Inpatient hospitals/acute care
- Outpatient care utilization
- Other service utilization, including clinic, physician, ambulance, home health, pharmacy and dental
- Vaginal and cesarean deliveries

In addition, the MCOs submit separate quarterly reports on the number of PCP visits within 90 days of enrollment, number of children receiving EPSDT services and the number of ER visits among members.

**Encounter data**

MCOs submit encounter data to the State on a monthly basis. The MCOs are required to certify the completeness and accuracy of each set of data submitted. A contractor to the State standardizes all data for coding and adds each month's data to a historical master file that allows for program-wide analysis. The contractor develops annual encounter data summary reports addressing a variety of health service areas.

- e. X Enrollee hotlines operated by State

The State's enrollment broker operates a toll-free hotline, through which members can enroll, request disenrollment or changes in MCO or PCCM, file complaints, and ask questions.

- 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. X Geographic mapping of provider network

The State evaluates geographic mapping analyses of existing MCO provider networks on an annual basis to ensure that the networks have adequate geographical coverage for all points within a county. Analysis of MCO provider networks current at the time of geographic mapping demonstrate whether the networks provide geographic access within the established travel and distance standards.

MCOs must also report significant changes in networks to the State, at which point plan and county specific analyses are conducted to ensure provider network standards are still being met.

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

i. \_\_\_\_\_ Measurement of any disparities by racial or ethnic groups

West Virginia's numbers of ethnic/racial minorities are too small to provide credible rates for comparison purposes.

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

The State requires each MCO to submit documentation assuring network adequacy at the following times: annually, prior to enrolling beneficiaries in a new service area, prior to enrolling a new population, prior to implementing a new benefit, on an ongoing basis through quarterly reporting, and immediately at any time there has been a significant change in the existing provider network that affects access and capacity.

MCOs that wish to begin enrolling beneficiaries in a new service area or in a new population must establish and maintain provider networks in geographically accessible locations for the populations to be served. Networks must be comprised of hospitals, PCPs, pharmacies, and specialty care providers in sufficient numbers to make all covered services available in a timely manner. The MCO must contract with sufficient numbers of providers to maintain equivalent or better access to that available under Medicaid fee-for-service. Each MCO is required to submit their full provider network, including all PCPs, specialists, pharmacies, and hospitals, to the State for review, and demonstrate that any services not available in the network, even if they are not available in the fee-for-service network, will be provided out-of-network if needed. The MCO

must also ensure providers are fully credentialed and submit directory documentation to the State for review prior to any new enrollment.

The State conducts an annual review of each MCO's provider network in each county to ensure they meet appropriate access standards. BMS also reviews each MCO's provider network directory to confirm that each provider is included in the directory and that the directory clearly indicates which PCPs are not accepting new patients.

MCOs must also submit detailed network information on a quarterly basis, to ensure that networks continue to be adequate and that access standards continue to be met. The State requires each MCO to report PCP-to-enrollee ratios and PCP panel sizes. These reports are reviewed to determine if there is sufficient capacity to serve members. Any significant network changes, such as PCP termination affecting many members, must be reported to the State immediately, along with a description of how the members in the terminated PCP's panel will be transitioned to different PCPs. The State will then conduct plan and county specific analyses to ensure provider network standards are still being met.

k.  Ombudsman

MCOs each have a Medicaid Member Advocate to assist members with filing grievances and addressing any other concerns they might have, but this does not constitute a formal ombudsman program.

l.  On-site review

The State's EQRO conducts an annual on-site review of each MCO's administrative and operational systems to ensure that the MCO has the appropriate structure in place to meet all program requirements. Compliance with service provision requirements regarding family planning services, emergency care services, and FQHC-based services are also part of the review.

The on-site systems performance review evaluates the following administrative and operational areas:

- Enrollee Rights and Responsibilities
- Grievance System
- Quality Assessment and Performance Improvement (QA)
- Provider Network Availability and Accessibility
- Credentialing and Recredentialing
- Utilization Management
- Health Information System
- Utilization Review



- Medical Records
- Health Education Plan

To prepare for the on-site review, the EQRO reviews documentation submitted by the MCO such as internal policies, procedures, member handbooks, provider handbooks, newsletters, meeting minutes, access and availability monitoring reports, and other documentation that are pertinent to the standards under review. During the on-site visit, the EQRO conducts interviews with key MCO personnel, examines actual case files, and reviews additional documentation to confirm operational compliance with all performance standards. Please see Appendix B-1, State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

m. X Performance improvement projects [**Required** for MCO/PIHP]

- X Clinical
- X Non-clinical

Each MCO must conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, sufficient and sustainable clinical care and non-clinical services that can be expected to have a favorable effect on health outcomes and enrollee satisfaction. These performance improvement projects must measure performance using objective quality indicators, implement system interventions to achieve quality improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements. Projects can be chosen from the following areas:

Clinical focus areas include:

- Primary, secondary, and/or tertiary prevention of acute conditions,
- Primary, secondary, and/or tertiary prevention of chronic conditions,
- Care of acute conditions,
- Care of chronic conditions,
- High-volume services,
- High-risk services, and
- Continuity and coordination of care.

Non-clinical focus areas include:

- Availability, accessibility, and cultural competence of services,
- Interpersonal aspects of care
- Appeals, grievances, and other complaints, and
- Effectiveness of communications with enrollees.

MCOs are required to maintain at least three projects to achieve meaningful improvement in three focus areas. The State has the option to

choose the focus areas. Project proposals must be approved by BMS and the EQRO prior to project initiation. After improvement is achieved, it must be maintained for at least one year before the project can be discontinued.

The State's EQRO conducts an annual review of each MCO's indicated performance improvement projects utilizing the CMS protocol, *Validating Performance Improvement Projects—A Project for Use in Conducting Medical External Quality Review Activities*. An annual report is completed for each MCO and an aggregate report is produced for BMS summarizing results and providing recommendations for improvement. Please see Appendix B-1, State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

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

To ensure ongoing quality of care in the MCO program, health plans are required to conduct and report a variety of performance measures, according to the Health Plan Employer Data and Information Set (HEDIS). The State's EQRO validates these MCO performance measures annually, in order to evaluate the accuracy of the measures and determine the extent to which they followed the specifications. Please see Appendix B-1, State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Each MCO must measure its performance in the areas listed using standard measures, as defined by the current version of HEDIS®. These measures must be reported to the State on an annual basis. In the last waiver period, MCOs were required to report HEDIS® 2013 (CY 2012) and HEDIS 2014 (CY 2013).

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

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

q.  Provider Self-report data

Survey of providers

Focus groups

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

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

For all non-MCO beneficiaries enrolled in the PCCM program, the Medicaid agency personnel including SURS personnel reviews reports of emergency room services for quality of care issues related to services inappropriately provided in the ER.

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.

This is a renewal request.

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

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

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes  
 No. Please explain:

Summary of results:  
Problems identified:  
Corrective action (plan/provider level)  
Program change (system-wide level)

**Strategy: Accreditation for Participation**

Confirmation it was conducted as described:

Yes  
 No. Please explain:

Summary of results:

No new MCOs joined the program in the last waiver period. All three WV MCOs have successfully completed the NCQA health plan certification process, including accreditation.

Problems identified: None  
Corrective action (plan/provider level): N/A  
Program change (system-wide level): N/A

**Strategy: Consumer Self-Report Data**

Confirmation it was conducted as described:

Yes  
 No. Please explain:

Summary of results:

MCOs conducted a survey of adults and children enrolled in each MCO in 2013 with results due to BMS on August 15, 2013. Two distinct populations were surveyed – adults and children in managed care. The MCOs were required to use the most current version (version 5.0) of the CAHPS survey, a nationally recognized health care survey developed by the Agency for Healthcare Research and Quality. Each MCO included the core set of questions related to health care delivery issues including: getting needed care, getting care quickly, how well doctors communicate, and health plan customer service, information, and paperwork. These questions provide respondents with the opportunity to rate their doctors, health plan, and overall health care. The surveys were conducted on behalf of the MCOs by NQCA-certified vendors.

*Results*

Overall survey results were positive for MCO members, with the majority of adult and child respondents reporting fast and easy access to care, and satisfaction with personal doctors, specialists, health plans, and health care overall. Findings to date for these members are detailed in the table below.

### Survey Findings for MCO Members

Survey Finding	Child MCO	Adult MCO
Percent of members who reported that they always or usually received the help or information they needed	92.7%	90.6%
Percent of members who always or usually get routine care as soon as they thought they needed	91.8%	82.2%
Percent of members who always or usually get the care they needed right away as soon as they thought they needed	95.3%	83.7%
Percent of members who said that doctors and other providers always or usually explained things in a way they could understand	93.8%	90.4%
Percent of members who said that doctors and other providers definitely or somewhat involved them in their treatment decisions	67.3%	73.8%
Percent of members who rated their health plan a "7" or higher on a 10-point scale	86.6%	72.7%
Percent of members who rated their health care a "7" or higher on a 10- point scale	84.0%	72.9%
Percent of members who have a personal doctor or nurse and rated them a "7" or higher on a ten point scale	87.3%	77.9%
Percent of members who saw a specialist and rated their specialist 7 or higher on a 10 point scale	84.7%	76.7%

The State will continue to require the MCOs to conduct member satisfaction surveys in the coming waiver period. The results show that overall child members are more satisfied with their doctors, health care, and health plan than adult members. The most likely explanation for this differential is that the adult members are in poorer health than child members, which negatively affects their perception of the health care system. CAHPS surveys in other states have also found similar correlations between self-reported health status and satisfaction levels. Given this confounding factor, the State does not have any specific concerns about the program in interpreting the results of the survey. However, the State will address these results through initiatives to improve member health status, such as MCO performance improvement projects. Each MCO is required to submit an action plan to improve performance for one or more measures that received a low rating compared with the other measures. The MCOs are required to provide quarterly updates on the progress of the action plans.

Regarding the PCCM program, please see information under Strategy: Data Analysis for a description of enrollee complaints related to provider access and satisfaction collected by the enrollment broker.

Problems identified: None

Corrective action (plan/provider level): N/A

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

**Strategy: Data Analysis (non-claims)**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

*Disenrollment Requests*

Ongoing monitoring of disenrollment requests and other enrollment changes has shown that the program is in compliance with the enrollment and disenrollment requirements. Disenrollment information is taken into consideration in ongoing program monitoring and quality assurance efforts.

In the MCO program, enrollees are able to switch from one MCO to another at any time, for any reason. The majority of PCP changes during the past waiver period were because the member’s provider was not in the plan. The actual percentage of members who change MCOs, however, is quite low, as seen in the table below.

**MCO Changes Over the Last Waiver Period**

Year	Month	Number of Changes	Percent of enrolled
2012	Jan	311	Less than 1%
	Feb	270	Less than 1%
	Mar	300	Less than 1%
	Apr	256	Less than 1%
	May	253	Less than 1%
	Jun	199	Less than 1%
	Jul	214	Less than 1%
	Aug	282	Less than 1%
	Sep	172	Less than 1%
	Oct	247	Less than 1%
	Nov	280	Less than 1%
	Dec	186	Less than 1%
2013	Jan	283	Less than 1%
	Feb	233	Less than 1%
	Mar	333	Less than 1%
	Apr	271	Less than 1%
	May	226	Less than 1%
	Jun	209	Less than 1%
	Jul	300	Less than 1%

	Aug	299	Less than 1%
	Sep	279	Less than 1%
	Oct	311	Less than 1%
	Nov	233	Less than 1%
	Dec	228	Less than 1%

In the PCCM program the majority of PCP changes relate to enrollee preference. The following chart shows the number of PCP changes in the PCCM program over the last waiver period. Enrollees who do not choose their PCP through the enrollment process are auto-assigned to a PCP; in some instances, these enrollees later call the enrollment broker to change back to their established or preferred PCP. The number of enrollees who were dissatisfied with their doctor in 2012 and 2013 and who requested a PCP change were low – in both years less than 1% of PCCM members called to change their PCP either due to auto-assignment or member complaints. Ongoing monitoring of these complaints by the enrollment broker and the State show that there are no underlying access or quality concerns.

#### PCCM Changes Over the Last Waiver Period

Year	Month	Number of Changes	Percent of enrolled
2012	Jan	13	Less than 1%
	Feb	11	Less than 1%
	Mar	13	Less than 1%
	Apr	13	Less than 1%
	May	9	Less than 1%
	Jun	11	Less than 1%
	Jul	15	Less than 1%
	Aug	7	Less than 1%
	Sep	11	Less than 1%
	Oct	11	Less than 1%
	Nov	7	Less than 1%
	Dec	14	Less than 1%
2013	Jan	22	Less than 1%
	Feb	11	Less than 1%
	Mar	6	Less than 1%
	Apr	13	Less than 1%
	May	6	Less than 1%
	Jun	6	Less than 1%
	Jul	9	Less than 1%
	Aug	6	Less than 1%
	Sep	5	Less than 1%
	Oct	11	Less than 1%
	Nov	3	Less than 1%
	Dec	3	Less than 1%

*Grievances and Appeals*



As shown in the summary table below, a small number of formal grievances were filed with the MCOs during the previous waiver period. The table below displays the number of formal grievances, by type, filed in each quarter of 2012 and 2013. Beginning in the second quarter of 2013, the quarterly reports were expanded to track informal and formal grievances related pharmacy services due to the program expansion. The State’s review of the grievance data indicates that there are no underlying concerns with access or quality.

**Formal Grievances Filed in Last Waiver Period**

Type of Grievance	2012				2013				TOTAL
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4*	
Service Denied	0	1	0	0	0	3	0	-	4
Payment Complaint	0	0	0	0	0	0	0	-	0
Service Complaint	1	0	0	0	0	0	0	-	1
Quality of Care	0	0	0	0	0	0	0	-	0
<b>Total</b>	1	1	0	0	0	3	0	-	5

*\*Note: Fourth quarter 2013 data is unavailable at time of waiver renewal submission.*

The State tracks the number of children with special health care needs and grievances filed by or on behalf of children with special needs and receives quarterly MCO reports to monitor whether children with special health care needs are receiving medically necessary services as defined in the MCO contracts. The quarterly reports demonstrate that very few complaints or grievances were filed on behalf of children with special health care needs during the last waiver period. During calendar years 2012 and 2013, none of the formal grievances filed were for children with special health care needs. The State’s review of the grievance data indicates that there are no underlying access or quality concerns.

Problems identified: None

Corrective action (plan/provider level): N/A

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

**Strategy: Enrollee Hotlines operated by State**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Each month the State’s enrollment broker, Automated Health Systems, Inc. (AHSI), sends a report on enrollment broker activities to the State, including hotline activity. A summary of the number and types of hotline inquiries is provided, including new enrollments, changes, complaints, outreach and referrals. Any errors made by hotline staff are also reported monthly.

Over the last waiver period, AHSI has successfully processed thousands of hotline calls each month. As part of internal quality review and monitoring, hotline staff routinely survey a selection of hotline callers to assess whether they felt they were treated well, if the call was conducted in a timely manner, and if they had all their questions answered.

Results of these survey calls over the last waiver period have been overwhelmingly positive.

The State reviews these reports regularly and has not determined there to be any access or quality concerns with the enrollee hotline.

Problems identified: None  
Corrective action (plan/provider level): N/A  
Program change (system-wide level): N/A

**Strategy: Focused Studies**

Confirmation it was conducted as described:

Yes  
 No. Please explain:

Summary of results:

Focused studies were not conducted in this waiver period; however, the State's external quality review organization (EQRO), Delmarva Foundation for Medical Care, closely monitors performance improvement projects (PIPs).

Problems identified: N/A  
Corrective action (plan/provider level): N/A  
Program change (system-wide level): N/A

**Strategy: Geographic mapping of provider network**

Confirmation it was conducted as described:

Yes  
 No. Please explain:

Summary of results:

In addition to evaluation of provider networks prior to county expansion, the State re-evaluates MCO network adequacy for all service areas annually. In fall 2012 and 2013, all MCO networks were re-evaluated to ensure the access standards were being met. MCOs were required to submit geographic data maps demonstrating the availability of over 30 different provider types throughout the service area. In addition, MCOs submitted data on member-to-provider ratios for PCPs and OB/GYNs and provided full lists of primary, specialty, ancillary, and facility providers in the network. The State reviewed the geographic maps and ratios against availability of FFS Medicaid providers to ensure its provider standards were met.

In this waiver renewal, the State is requesting authority to expand the service area of one MCO, The Health Plan. Appendix C-1 includes detailed network documentation demonstrating network adequacy for THP within the requested service area.

Problems identified: None  
Corrective action (plan/provider level): N/A

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

**Strategy: Network adequacy assurance submitted by plan**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

As described above, MCOs are required to submit documentation of network adequacy annually. BMS reviewed information submitted by each MCO to ensure provider networks remained adequate.

In the eighth waiver period (2012-2014), Coventry and THP expanded their service areas to include new counties. Prior to expansion, each MCO was required to develop an adequate provider network for each county of interest and submit documentation to the State demonstrating that the network is adequate. Full provider networks, including PCPs, specialists, ancillary providers, and hospitals, were submitted to the State for review, along with assurances that all covered services would be provided in a timely manner, on an out-of-network basis if necessary. The State reviewed these networks against established network adequacy benchmarks to determine adequacy. In many cases, the network was not deemed adequate right away, and the MCO was required to add more providers in particular specialties before the network was considered complete. Once the network was deemed adequate, the MCO was required to submit directory materials showing that they appropriately listed all providers.

In this waiver renewal, the State is requesting authority to expand THP's service area. Detailed network documentation is included in Appendix C-1.

To ensure that networks continue to be adequate on an ongoing basis, MCOs are required to submit quarterly assurance of adequacy through a PCP panel report. The MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions within 14 days. The MCO must report any disenrollment of hospitals from the MCO's network to BMS immediately. Review of these reports over the last waiver period showed that PCP access is more than sufficient, demonstrated by overall low panel sizes in the program. Very few PCP panels approached the State's 2,000 member limit. The average PCP panel size is approximately 54 members. In addition, specialist access was maintained at a steady level.

Problems identified: None

Corrective action (plan/provider level): N/A

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

**Strategy: On-site review**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

In the last waiver period, the State’s EQRO, Delmarva Foundation for Medical Care, conducted a systems performance review of each MCO, including on-site evaluation, as part of the annual external quality review. The systems performance review (SPR) provides an annual assessment of MCO structures, policies, and processes to determine compliance with federal, state, and contract standards. To accomplish the SPR, Delmarva staff conducted an evaluation of each MCO’s administrative and operational systems to assess whether the MCO had the appropriate structure in place and had implemented key operational policies and procedures to meet statutory and contractual requirements. Prior to the review, Delmarva reviewed the statutory and contractual requirements to ensure that they were assessing the MCOs on all required standards. Delmarva requested pre-site documentation to conduct a desk review prior to the on-site review. Pre-site materials were uploaded by the MCO to the secure Delmarva website. The pre-site information was then accessed and evaluated by the Delmarva reviewers prior to the on-site review. Following the desk review, an on-site review was conducted at the MCO’s central office. At the time of the on-site review additional data were collected through various means such as conducting staff interviews, reviewing case management, grievance, appeals and credentialing files, and assessing the functioning of electronic systems (e.g. preauthorization).

The SPR was conducted in a manner consistent with CMS *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations*. Each element within a performance standard was rated as “met,” “partially met,” or “unmet.” Based on this rating scale, each element was then assigned a numeric value. The total of all element scores within a performance standard was averaged to determine overall compliance for the particular standard. The total of all standard scores were averaged to develop an overall score for the SPR.

All three MCOs scored very high in the on-site review. The following table displays each MCOs most recent SPR results.

**Results of Systems Performance Review – CY 2012**

<b>Performance Standard</b>	<b>Coventry Compliance Rate</b>	<b>THP Compliance Rate</b>	<b>UniCare Compliance Rate</b>
Quality Assessment and Performance Improvement	100%	99%	99%
Enrollee Rights	100%	100%	100%
Grievance Systems	100%	98%	100%
Fraud and Abuse	98%	93%	100%

Results of the review included detailed information on each MCO’s strengths and areas for improvement. The full EQR report for each MCO is available upon request. The EQRO will continue to perform an annual on-site systems performance review during the next waiver period.

Problems identified: None  
Corrective action (plan/provider level): N/A  
Program change (system-wide level): N/A

**Strategy: Performance Improvement Projects**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

In the last waiver period, the State increased the number of required performance improvement projects (PIPs) from two to three. The State's EQRO, Delmarva Foundation for Medical Care, reviewed each MCO's chosen PIPs as part of the annual external quality review. Delmarva conducted an evaluation of the methodology and outcomes reported by each MCO for each clinical and service PIP to ensure that PIPs were designed, conducted, and reported in a methodologically sound manner. Delmarva provided an individual evaluation for each PIP and provided educational opportunities, where appropriate, to the MCO for use in improving its PIPs. The following describes the most recent performance improvement projects for each MCO.

*CoventryCares*

CoventryCares conducted PIPs in three areas: Improving Compliance with Adolescent Well-Care Visits, Decreasing Emergency Department Utilization Rates and Improving Diabetes Care. PIP strengths were noted to be:

- CoventryCares improved compliance with the Adolescent Well-Care Visit HEDIS measure by nearly 4.5% between 2011 and 2012.
- CoventryCares implemented an incentive for providers who decreased ER utilization. CoventryCares produced and distributed "Gaps in Care" reports to providers to encourage them to perform outreach to patients that need to receive diabetes tests and services.

*THP*

THP conducted PIPs in the following areas: Improving Childhood Obesity Care, and Reducing Emergency Room Utilization and Improving Diabetes Care. PIP strengths were noted to be:

- THP performed outreach and education to providers regarding appropriate childhood obesity care and documenting such activities in the care record.
- THP performed outreach and provided case management on a monthly basis to members who visited the ER more than 3 times within 6 months.
- THP achieved significant improvement in the indicator related to emergency room visits with a respiratory diagnosis and back pain.

- THP used the Wellness and Health Promotion Call Center, which identified diabetic members missing important services and/or testing through claims data and provided one-on-one personalized contact with them and their PCP.

*UniCare*

UniCare conducted PIPs in three areas: Improving Compliance with Childhood Immunizations, Reducing Inappropriate Emergency Room Utilization, and Improving Diabetes Care. PIP strengths were noted to be:

- UniCare provided an incentive to parents and caregivers when a child completed 6 of the 8 well visits recommended before 15 months of age.
- UniCare significantly reduced the number of ER visits by members in two large practices.
- UniCare provided an incentive for members that completed diabetes screenings and annual eye exams.

The full EQR report for each MCO, including a detailed report for the performance improvement project review, is available upon request. The State submits a copy of the Annual Technical Report, which includes information on performance improvement projects, to CMS annually. The EQRO will continue to perform an annual review of each MCO’s performance improvement projects during the next waiver period.

Problems identified: None

Corrective action (plan/provider level): N/A

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

**Strategy: Performance measures**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

In the last waiver period, MCOs were required to report their performance to the State through selected HEDIS measures. In SFY2013, the State also began requiring the MCOs to report applicable measures from the US Department of Health and Human Services’ Child and Adult Core Sets. Each MCO’s HEDIS measures were validated by the EQRO. As part of the validation, the measures were audited by an NCQA-certified auditor. MCO HEDIS results from measurement year 2012 are included in the Annual Technical Report, which the State submits to CMS annually. Detailed audit findings are also included in individual plan-specific reports, which may be provided upon request.

Results show that in some cases the MCO performance is greater than the HEDIS Medicaid average, whereas in others it is lower. MCOs often develop performance improvement projects in areas where they are performing below standard levels. It is also important to note that differences in performance may be due to many factors, including the following:

- Administrative versus hybrid collection methodology – the hybrid methodology is less likely to result in underreporting of events, but may be too costly for an MCO to use in every measure,
- Member population characteristics – the measures do not take into account member factors, such as member education, initial health status, location (urban vs. rural), that may affect health care patterns but are beyond the MCO’s control, and
- MCO characteristics – newer and smaller MCOs may not have the population or year of data required to produce statistically sound measures.

The State considers these factors in evaluating MCO performance measures and has selected certain measures for focus in the Quality Strategy and other quality programs, such as the Performance Incentive Program. The State will continue to work with the MCOs to identify areas for improvement and ways to increase positive health care patterns in the program.

Problems identified: None

Corrective action (plan/provider level): N/A

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

**Strategy: Utilization Review**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Over the last waiver period, the State conducted prior authorization and utilization review for all non-MCO beneficiaries, including those enrolled in the PCCM program. As shown in the table below, the majority of inpatient prior authorizations are for acute care services, while the majority of outpatient prior authorizations are for imaging and durable medical equipment.

**2011 Prior Authorization Summary**

Type of Service	Completed Reviews			Decisions	
	Total Requests	Total Recipients	Retro %	% Requests Approved	% Requests Denied
<b>INPATIENT SERVICES</b>					
Acute Care					
In State	22,459	13,862	68.5%	79.5%	15.1%
Out of State	488	337	62.1%	73.0%	16.8%
Border	2,455	1,645	59.3%	83.7%	10.9%
Critical Access	925	679	69.3%	77.9%	18.3%
Adult Psych	0	0	0.0%	0.0%	0.0%
BMU	0		0.0%	0.0%	0.0%
Inpatient Rehab <21	72	18	4.2%	87.5%	4.2%
Transplants	56	41	8.9%	85.7%	0.0%

<b>Inpatient Total</b>	<b>26,455</b>	<b>16,582</b>	<b>67.3%</b>	<b>79.8%</b>	<b>14.8%</b>
<b>OUTPATIENT SERVICES</b>					
Chiropractic	235	162	1.3%	93.2%	5.1%
Durable Medical	22,453	13,280	1.6%	79.2%	13.8%
General Dental	7,732	6,716	1.5%	93.0%	6.5%
Orthodontics	4,170	4,007	0.0%	75.7%	24.1%
Home Health	1	1	100.0%	100.0%	0.0%
Home IV Therapy	0		0.0%	0.0%	0.0%
Orthotics	767	602	0.8%	62.7%	35.9%
Partial Hospitalization	0		0.0%	0.0%	0.0%
Physical Therapy	325	258	2.5%	16.6%	77.8%
Private Duty Nursing	380	87	5.5%	71.6%	9.2%
Prosthetics	46	37	0.0%	73.9%	26.1%
Speech Therapy	679	389	0.0%	68.2%	29.3%
Vision	0		0.0%	0.0%	0.0%
Imaging	34,316	18,434	5.1%	73.1%	24.0%
Outpatient Surgery	8,504	5,765	13.5%	82.3%	13.3%
<b>Outpatient Total</b>	<b>79,740</b>	<b>49,849</b>	<b>4.3%</b>	<b>77.5%</b>	<b>18.6%</b>

The State has not detected any problems with individual provider service patterns in the program. In the coming waiver period, the State will continue to monitor utilization and prior authorization patterns in the PCCM program.

Problems identified: None

Corrective action (plan/provider level): N/A

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



## 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:  
Tina Bailes
- c. Telephone Number: 304-356-4843
- d. E-mail: Tina.R.Bailes@wv.gov
- e. The State is choosing to report waiver expenditures based on  
 date of payment.  
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

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

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

**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: \$ 3.00 per member per month fee
  - 2.  Second Year: \$ 3.00 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.  [Required] Population in the base year and R1 and R2 data is the population under the waiver.  
  
TANF pregnant women, SSI children, and SSI adults, TANF 1931 parent and caretaker population, TANF medically needy population, and TANF Children with Special Health Care Needs (CSHCN) who also have coverage under Title V.
- b.  For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:  
  
Enrollment projections were trended based on the historical enrollment patterns for the waiver population. SSI eligibles were not enrolled in

managed care during R1 or R2; however, the total number of SSI eligibles was inputted into Appendix D1 to obtain a comparison PMPM under the waiver in P1 and P2. Waiver program SSI eligibles were estimated by identifying member months in the respective managed care eligible SSI rate codes in the eligibility data from the state's fiscal agent. Likewise, the member months for the TANF pregnant women, TANF 1931 parents and caretakers, TANF medically needy, and TANF CSHCN were identified based on the rate codes applicable to these populations in the eligibility data for both those members who are enrolled in the MCOs or in PAAS (the state's PCCM program). The former Mountain Health Choices (MHC) TANF population was rolled into the waiver on January 1, 2014. These member months were included for projection purposes but the costs were not since they were not in the waiver in R1 or R2 but were used for the waiver cost projection

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

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

R1 represents State Fiscal Year (SFY) 2013 (July 1, 2012 – June 30, 2013) and R2 represents SFY 2014 (July 1, 2013 – June 30, 2014).

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

The services included in the R1 and R2 periods are the services that were included in the prior waiver submission. These services include those that are in the managed care benefits package and some services remaining carved-out in FFS that are directly impacted by the MCOs. Pharmacy services were carved in to managed care effective 4/1/2013 (R1). FFS Pharmacy cost prior to the carve-in and for FFS populations after the carve-in were included as FFS services which are impacted by the MCOs.

We used the FFS pharmacy costs, net federal and state supplemental rebates, for the waiver population. Pharmacy costs were included in the managed care capitation amount for part of R1 and all of R2.

The actual waiver costs entered into Appendix D3 include the FFS experience during the R1 and R2 periods for the services included in the prior waiver submission

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

No services covered under the managed care benefits package were excluded from the data in the development of R1 or R2 costs. As institutionalized and waiver populations are not eligible for managed care or the PCCM program, we excluded nursing facility, ICF/MR, psychiatric residential treatment facility (PRTF), HCBS waiver services, and mental health facility as persons accessing these services will not be covered under the waiver. Overall, line items on the CMS-64 that were excluded are: Inpatient DSH, Mental Health Facility, DSH, ICF Public and Private, nursing facility, and home and community-based waiver services, as well as PRTF services from the mental health facility line category.

**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.

<b>Additional Administration Expense</b>	<b>Savings projected in State Plan Services</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Total</i>	<i>N/A</i>		<i>N/A</i>

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

- a. X The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. Note: this is appropriate for MCO/PCCM programs.
- b. \_\_\_ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Note: this is appropriate for statewide PIHP/PAHP programs.
- c. \_\_\_ Other (Please explain).

**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

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

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

<b>1915(b)(3) Service</b>	<b>Amount Spent in Retrospective Period</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>N/A</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Total</i>	<i>N/A</i>		<i>N/A</i>

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:

Within the mandatory waiver population, beneficiaries may choose to enroll in either the MCO or PCCM program in some counties. In previous years, the capitation rate methodology included a selection bias adjustment factor for counties in which mandatory waiver population has the choice of MCO or PCCM as the managed care entity. For SFY 2012, the State removed the selection bias adjustment as the analysis of the MCOs’ indicates they have not experienced favorable selection. This selection bias adjustment will be revisited periodically and reinstated should the MCOs’ experience show the plans have begun to receive favorable selection.

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



costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. X The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. \_\_\_ The State provides stop/loss protection (please describe):

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

1. X [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.

An MCO performance incentive program was implemented and the first payout was after the retrospective years. The resulting payout is a maximum of 1.5% of total capitation paid to MCOs annually, based on quality metrics from the prior year. Capitation rates were set toward the bottom of the actuarially sound rate range so that total capitation and incentive bonus paid will be within the rate range.

BMS used statewide scores for each MCO for three (3) HEDIS measures:

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life,
- Prenatal and Postpartum Care – Postpartum Care, and
- Childhood Immunization Status – Combination 3.

Scores from calendar year (CY) 2012 were used for the State Fiscal Year (SFY) 2013 program, which ran from July 1, 2012, through June 30, 2013. The results are documented in Appendix D-

8: SFY 2013 Performance Incentive Payments. Similarly, scores from calendar year (CY) 2013 will be used for the State Fiscal Year (SFY) 2014 program, which runs from July 1, 2013, through June 30, 2014. BMS will analyze MCO performance and award applicable incentives based on audited HEDIS results submitted to BMS.

Starting in SFY15, BMS will withhold 5% of the capitation rate and give MCOs the opportunity to earn it back through achievement of performance standards, as described in the state quality strategy in Appendix B-1 and Exhibit G of the SFY15 MCO contract. The incentive will be paid outside of the capitated payments, but, combined with the capitated payments, the potential amount paid still falls within the actuarially sound rate range.

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: \_\_\_\_\_. 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):

1. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
  1. \_\_\_ This adjustment is not necessary as there are no voluntary populations in the waiver program.
  2. \_\_\_ This adjustment was made:
    - a. \_\_\_ Potential Selection bias was measured in the following manner:
    - b. \_\_\_ The base year costs were adjusted in the following manner:
  
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
  1. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
  2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
  3. \_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
  4. \_\_\_ Other (please describe):

**Special Note section:**

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

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

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

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

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

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

*Documentation of assumptions and estimates is required for this adjustment.*

1. \_\_\_\_ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2. \_\_\_ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
  3. \_\_\_ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. \_\_\_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  2. \_\_\_ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
      1. \_\_\_ No adjustment was made.
      2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection,

that the State did not expend funds associated with the adjustment that was not implemented.

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

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

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The 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: 3.52% annually. Please document how that trend was calculated:

Because R2 is not a complete year, the PMPM costs from R2 to P1 were trended at the 3.52% annual rate for 15 months (the difference from the midpoint of 2013 Q3 and Q4 to SFY15). The total trend from R2 to P1 is 4.86%.

For the services covered under the managed care capitation payment, the trending method was similar to the trend methodology used in previous years' rate setting (most recently the BBA-compliant SFY 2014 capitation rate derivation approved by CMS in the spring of 2013). The trend rate was calculated by applying two types of trend factors: one for price changes, and another to account for changes in the rate of utilization of medical services and in the mix of medical services that are utilized.

The price trend reflects the impact of unit price changes that have been enacted to date, as determined by the West Virginia Medicaid program's provider payment policies.

We developed a utilization trend for each of the four main categories of service: inpatient hospital, outpatient hospital, physician, and other.

These trends represent our estimate of the portion of the expected change in PMPM costs that is attributable to factors other than price changes (such as changes in the number of services used per participant, as well as changes in practice or consumption patterns that affect the mix or the intensity of the services used).

For pharmacy services, historical PMPM costs from CY 2012 and CY 2013, net of rebate, were blended with changes in Medicaid per capita costs from the National Health Expenditures developed by the CMS Office of the Actuary to estimate annual trends.

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
- i. X State historical cost increases. Please indicate the years on which the rates are based: base years: Trends were based on price and programmatic changes from SFY 2013 to SFY 2014 and CMS-64 expenditure data from CY 2012 and CY 2013 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.

As mentioned above in J.a.1, this trend methodology was used in the most recent capitation rate derivation approved by CMS in the spring of 2011. The trend rate was calculated by applying two types of trend factors: one for price changes, and another to account for changes in the rate of utilization of medical services and in the mix of medical services that are utilized.

The price trend reflects the impact of unit price changes that have been enacted to date, as determined by the West Virginia Medicaid program's provider payment policies.

We developed a utilization trend for each of the four main categories of service: inpatient hospital, outpatient hospital, physician, and other. These trends represent our estimate of the portion of the expected change in PMPM costs that is attributable to factors other than price changes (such as changes in the number of services used per participant, as well as changes in practice or consumption patterns that affect the mix or the intensity of the services used).

The utilization trends that we developed are derived from the following sources:

1. Historical cost and utilization obtained from the MCOs' reported encounter data for those TANF beneficiaries enrolled in an MCO. We used the PMPM cost trend as well as units per 1,000 trends from the MCOs' experience for these beneficiaries.
  2. Historical fee-for-service costs for those managed care eligible TANF beneficiaries remaining in the PCCM program and the managed care eligible SSI population. We used the respective PMPM cost trends as well as units per 1,000 trends from SFY 2012 to SFY 2013 for these beneficiaries.
- ii. X National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used See discussion in J.a.2.i above. 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.

See discussion in J.a.2.i above.

3. X 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). See discussion in J.a.2.i above.
    - ii. Please document how the utilization did not duplicate separate cost increase trends. See discussion in J.a.2.i above.
- b. X **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.

Past State programmatic/policy/pricing changes were included in the State Plan Services Trend Adjustment and were not included here. No future programmatic or policy changes are anticipated 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. \_\_\_ Other (please describe): \_\_\_\_\_
- ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.



- iii. \_\_\_ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. \_\_\_ Changes brought about by legal action (please describe):  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe): \_\_\_\_\_
- v. \_\_\_ Changes in legislation (please describe):  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe): \_\_\_\_\_
- vi. \_\_\_ Other (please describe):
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe): \_\_\_\_\_

c. X **Administrative Cost Adjustment\***: 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. X An administrative adjustment was made.
- i. \_\_\_ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
  - ii. X Cost increases were accounted for.
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. X State Historical State Administrative Inflation. The actual trend rate used is: 3.22% annually. Please document how that trend was calculated:

Administrative costs were calculated using the SFY 2013 and CY 2013 Q3 and Q4 CMS 64.10 reports. Administrative PMPMs for each MEG were calculated based on the distribution of waiver member months within each MEG. These PMPM costs were compared to SFY 2012 cost to establish an annual historical trend rate of 2.33% which was used in trending forward to P1 and P2. The retrospective period was trended to P1 using a factor of 3.22% which represents 15 months for trend and to P2 using the annual rate of 2.33%.

D. \_\_\_ Other (please describe):

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

- 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. 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.
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**:

Member months decreased slightly between R1 and R2 but were trended based on historical trends to develop P1 and P2. See E.c for explanation of trend derivation.

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**:

PMPM claims cost trends are separated into price and utilization components. See J.a.2.i for explanation of trend derivation.

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**:

PMPM claims cost trends are separated into price and utilization components. See J.a.2.i for explanation of trend derivation.

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

## **Part II: Appendices D.1-7**

Please see attached Excel spreadsheets.