Section 1915(b) Waiver
Proposal For
Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM) Programs
and
Fee-for-Service (FFS) Selective Contracting Programs

Renewal Waiver Submittal
Mountain Health Promise

Submitted by the State of West Virginia
Department of Human Services
Bureau for Medical Services

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MMA Amendment Version
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Table of Contents

Proposal

Facesheet 3
Section A: Program Description 5
Part I: Program Overview 5
A. Statutory Authority 7
B. Delivery Systems 9
C. Choice of MCOs, PIHPs, PAHPs, and PCCMs 11
D. Geographic Areas Served by the Waiver 14
E. Populations Included in Waiver 18
F. Services 21
Part II: Access 25
A. Timely Access Standards 25
B. Capacity Standards 28
C. Coordination and Continuity of Care Standards 31
Part III: Quality 35
Part IV: Program Operations 38
A. Marketing 38
B. Information to Potential Enrollees and Enrollees 42
C. Enrollment and Disenrollment 45
D. Enrollee Rights 51
E. Grievance System 52
F. Program Integrity 55

Section B: Monitoring Plan 58
Part I: Summary Chart 59
Part II: Monitoring Strategies 61

Section C: Monitoring Results 74

Section D: Cost Effectiveness 92
Part I: State Completion Section 92
Part I: Appendices D1-7 121

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

Facesheet

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

The **State** of __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 Promise (MHP), formerly referred to as Specialized Managed Care Plan for Children and Youth. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

____ initial request for new waiver. All sections are filled.

____amendment request for existing waiver, which modifies Section/Part _____

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

_X_ 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.

_X_ 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

_X_ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_X_ 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

_X_ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

_X_ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective July 1, 2024 and ending June 30, 2026. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Susan Deel and can be reached by telephone at (304) 352-4294, or fax at (__)____, or e-mail at Susan.H.Deel@wv.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

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

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 is for West Virginia's full-risk managed care program, Mountain Health Promise (MHP), formerly referred to as Specialized Managed Care Plan for Children and Youth. The current waiver was approved for the period of July 1, 2021 and ending on June 30, 2023. CMS has approved a series of 90-day temporary extensions that began July 1, 2023 and will end June 30, 2024. This waiver renewal request is for a 24-month period for an effective date beginning July 1, 2024 and ending June 30, 2026.

Per W.Va. Code §9-5-27 (2019 House Bill [HB] 2010 created this article), this managed care program seeks to reduce fragmentation and offer a seamless approach to participants' needs, deliver needed supports and services in the most integrated and cost-effective way possible, provide a continuum of acute care services, and implement a comprehensive quality approach across the continuum of care services.

This specialized managed care program provides comprehensive physical and behavioral health care, children's residential care, and socially necessary services to select beneficiaries who are in foster care or receive adoption assistance, and children eligible for serious emotional disorder home and community based services (HCBS).

This waiver runs concurrent with the State's Children with Serious Emotional Disorders (CSED) 1915(c) waiver to allow BMS to provide HCBS services, and the Section 1115 Substance Use Disorder (SUD) to allow enrollment into one specialized MCO.

The MHP program will provide statewide physical and behavioral health managed care services for the following populations:

- Children and youth up to age twenty-one (21) who are in the foster care system.
- Individuals up to age twenty-one (21) receiving adoption assistance.

- Youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the State of West Virginia. This population is effective at the start of the renewal waiver period.

- Children ages three (3) to age twenty-one (21) eligible for the Children with Serious Emotional Disorders (CSED) waiver and enrolled with the MCO as slots are available.

As of December 2023, approximately 26,000 individuals were enrolled in MHP.

The State closely monitors the MHP program processes and policies to identify program and quality improvements.

- The State operates a DOJ Executive Steering Committee that includes representation from the Secretary of the Department of Human Services (DoHS) office, Bureau for Medical Services (BMS), Bureau for Social Services (BSS), and other consultants to the State. The Committee conducts meetings to 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 meetings when necessary, raising issues of concern to their constituencies and obtaining information about the program to share with their staff and beneficiaries.

- The State continues to leverage Early Periodic Screening Diagnostic Testing (EPSDT) data to monitor the MHP program.

With its most recent MCO procurement, the State included requirements to increase accountability and enhanced the program by requiring the MCO to undertake new initiatives, such as but not limited to the following, beginning in July 2023:

- Added more intensive care management requirements.

- Included telehealth requirements.

- Added requirements to adopt strategies per the NCQA Health Equity Accreditation or Health Equity Accreditation Plus programs.

A. Statutory Authority

1. **<u>Waiver Authority</u>.** 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. _X_ **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. _X_ **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

_X_ 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. **<u>Sections Waived</u>.** 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):

_X_ **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.**

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

The State contracts with one specialized MCO to provide MHP services statewide.

- Medicaid beneficiaries who are children and youth in foster care or individuals receiving adoption assistance have a choice to receive services through the specialized MCO or through the FFS delivery system in all fifty-five (55) counties in West Virginia.
- Medicaid beneficiaries who are youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the State of West Virginia have a choice to receive services through the specialized MCO or through the FFS delivery system in all fifty-five (55) counties.
- Children eligible for MHP through the CSED waiver are mandatorily enrolled in the specialized MCO and do not have the option to disenroll into FFS. The Section 1115 Substance Use Disorder (SUD) waiver allows the State to require individuals who enroll in the CSED waiver to enroll with the one specialized MCO.

___ 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.
_X_ Other: (please describe)

Below is information about enrollment of each of populations. Section A.IV.C, Enrollment and Disenrollment, provides information about the notice that enrollees and their guardians receive to explain the enrollment process and how to disenroll to the fee-for-service delivery system for enrollees who are eligible to do so.

Enrollment for children in foster care defaults to the specialized MCO.

- BSS Child Protective Services (CPS) workers are responsible for enrollment decisions for children in foster care and receive training on the managed care enrollment and disenrollment processes.
- BSS CPS workers responsible for children in foster care may call a toll-free number to the State's MMIS vendor to disenroll a child from the specialized MCO and enroll in FFS. The decision to opt out of managed care may be made at any time between the original date of notice of enrollment in managed care or at any point after enrollment with the MCO.

Enrollment for individuals in the eligibility category for youth formerly in foster care up to age twenty-six (26) defaults to the specialized MCO.

- The State send eligible youth a letter explaining the effective date of the MCO enrollment, the benefits of managed care, and the option to disenroll to FFS.
- Eligible youth may call a toll-free number to the State's MMIS vendor to disenroll a child from the specialized MCO and enroll in FFS. The decision to opt out of managed care may be made at any time between the original date of notice of enrollment in managed care or at any point after enrollment with the MCO.
- Eligible youth who are enrolled with the specialized MCO will receive an annual notice of the option to disenroll into FFS.

Enrollment for children in adoption assistance defaults to the specialized MCO.

- The State sends families with children in adoption assistance a letter explaining the effective date of the MCO enrollment, the benefits of managed care, and the option to disenroll to FFS.
- Families with children in adoption assistance may call a toll-free number to the State's MMIS vendor to disenroll a child from the specialized MCO and enroll in FFS. The decision to opt out of managed care may be made at any time between the original date of notice of enrollment in managed care or at any point after enrollment with the MCO.
- Families with children in adoption assistance who are enrolled in the specialized MCO will also receive an annual notice of the option to disenroll into FFS.

Children eligible through the SED waiver will be mandatorily enrolled in the specialized MCO and will not have the option to disenroll into FFS. The Section 1115 SUD waiver allows enrollment into one specialized MCO.

3. **Rural Exception.**

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

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

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

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

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

D. Geographic Areas Served by the Waiver

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

_X_ **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.

The table below applies to children in foster care, former foster youth up to age twenty-six (26), and adoption assistance. **Note:** Children eligible through the CSED waiver are mandatorily enrolled in the specialized MCO and will not have the option to disenroll into FFS. The Section 1115 SUD waiver allows enrollment into one specialized MCO.

City/County/ Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Barbour	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Berkeley	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Boone	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Braxton	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Brooke	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Cabell	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Calhoun	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Clay	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Doddridge	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Fayette	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Gilmer	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)

City/County/ Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Grant	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Greenbrier	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Hampshire	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Hancock	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Hardy	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Harrison	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Jackson	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Jefferson	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Kanawha	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Lewis	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Lincoln	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Logan	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Marion	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Marshall	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Mason	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
McDowell	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Mercer	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Mineral	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Mingo	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Monongalia	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)

City/County/ Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Monroe	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Morgan	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Nicholas	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Ohio	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Pendleton	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Pleasants	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Pocahontas	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Preston	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Putnam	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Raleigh	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Randolph	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Ritchie	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Roane	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Summers	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Taylor	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Tucker	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Tyler	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Upshur	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Wayne	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Webster	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)

City/County/ Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Wetzel	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Wirt	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Wood	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)
Wyoming	Default to one MCO with FFS opt out option	Aetna Better Health of West Virginia (ABHWV)

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. **<u>Included Populations</u>**. The following populations are included in the Waiver Program:

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

_X_ Mandatory enrollment
___ Voluntary enrollment

Children qualifying for the State's CSED waiver are mandatorily enrolled with this specialized MCO to receive services.

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

_X_ **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
_X_ Voluntary enrollment

Children and youth in foster care, former foster youth up to age twenty-six (26), and individuals receiving adoption assistance are enrolled into managed care and the specialized MCO by default and have the option to disenroll from the MCO and instead utilize the FFS delivery system.

___ **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:

_X_ **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))

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

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

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

_X_ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

_X_ **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).

HCBS Waiver populations are exempt, except children eligible for the approved 1915(c) SED Waiver (1646.R00.00) called Children with Serious Emotional Disorders Waiver (CSEDW).

___ **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.

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

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

Individuals are enrolled in the MCO effective the first (1st) of the month when found eligible for foster care and managed care at any time during the month. The MCO will not be responsible for retroactive coverage beyond the month of enrollment.

___ **Other** (Please define):

F. Services

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

1. **Assurances.**

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

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

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

_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:

_X_ 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.

This applies to children and youth in foster care, individuals receiving adoption assistance, and former foster youth up to age twenty-six (26).

_X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least

one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

This applies to children eligible through the 1915(c) CSED waiver who are mandatorily enrolled in the specialized MCO and do not have the option to disenroll into FFS. The Section 1115 Substance Use Disorder waiver allows enrollment into one specialized MCO.

Per West Virginia's contract with the MCO, the MCO must allow the enrollee to access services at an out-of-network FQHC if the MCO cannot satisfy the standard access requirements for these services. This requirement is applicable to all populations accessing services under the MCO.

___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.**

_X_ 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:

- Following implementation of new benefits or populations in the managed care benefit package, enrollees may self-refer to a provider for up to sixty (60) 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/PPCM 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.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):
4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

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

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

B. Capacity Standards

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

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

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

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

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

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

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

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

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

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

Statewide Average: (e.g. 1:500 and 1:1,000)	

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 and the specialized MCO has mechanisms to identify persons with special health care needs including:

1. All children and youth entering or re-entering foster care must have both a comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam within thirty (30) calendar days of placement in Foster Care and a follow-up visit within ninety (90) calendar days of placement in Foster Care. For children receiving adoption assistance, the MCO is required to ensure that clinical nursing staff complete an initial assessment of each enrollee's health care needs within ninety (90) calendar days of the effective date of enrollment.

2. In addition, the Office of Maternal Child & Family Health (OMCFH) sends the fiscal agent a daily enrollment file of the children enrolled in the State's Children with Special Health Care Needs Program. This enrollment is added as an attribute to the system and shared with the specialized MCO as part of its enrollment roster.
3. The Department encourages the use of the American Academy of Pediatrics Healthy Foster Care Form as a guide by which the MCO can evaluate its membership as part of its care coordination stratification process. While the MCO shall not be responsible for the placement of the child, the form can still be useful for documenting basic health information.

   https://downloads.aap.org/AAP/PDF/Foster%20Care/Health_Form.pdf
4. The MCO must have procedures for identifying individuals with complex or serious medical conditions. The MCO must complete identification and assessment of the individuals with complex or serious medical conditions within ninety (90) calendar days of the effective date of enrollment in the MCO. The MCO must use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring.

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 all children entering or re-entering Foster Care have both a comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam within thirty (30) calendar days of placement in Foster Care; and a follow-up visit within ninety (90) calendar days of placement in Foster Care. For other enrollees, the MCO must ensure that an initial screening of each enrollee's health care needs is completed within thirty (30) calendar days of the effective date of enrollment.

For CSEDW enrollees, a wraparound facilitator engages with the enrollee and family to partner in the development of a Plan of Care (POC). The wraparound facilitator assists enrollees and families through:

- Ensuring and coordinating a comprehensive set of supports, resources, and strategies for each enrollee and family.
- Working closely with service providers to assure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes for enrollees and parents/legal representatives/ foster parents (when applicable).
- Leading the Child and Family Team (CFT) through engagement and team preparation, initial plan development, plan implementation, and transition, and provide intensive case management. This includes development and

implementation of a transition plan for participants who will reach the Waiver's maximum age limit of twenty-one (21).

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.

The MCO must make all efforts to assure that a person-centered treatment plan is developed:

- In collaboration with the enrollee's primary care provider (PCP);
- With participation from the enrollee and the enrollee's care manager (if a separate care manager has been designated in addition to the PCP); and
- In consultation with any specialists caring for the enrollee.

The treatment plan must meet applicable quality assurance and utilization standards. These treatment plans must be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

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. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. ___ Each enrollee is receives **health education/promotion** information. Please explain.

d. __ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ___ There is appropriate and confidential **exchange of information** among providers.

f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

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

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

Section A: Program Description

Part III: Quality

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

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

The State's quality strategy, "West Virginia Managed Care Strategy," describes the State's approach to quality for all managed care programs including Mountain Health Promise, Mountain Health Trust and WVCHIP.

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

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

_X_ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office in 2021.

_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):

The State contracts with an EQRO to perform the mandatory EQR activities and optional activities as noted. The State uses data obtained from the mandatory and optional EQR-related activities for the detailed annual EQR technical report that summarizes findings on access and quality of care by the MCO for the populations covered under this managed care waiver.

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Qlarant Quality Solutions, Inc.	Systems Performance Review	X	
	Qlarant Quality Solutions, Inc.	Performance Improvement Project Review	X	
	Qlarant Quality Solutions, Inc.	Performance Measure Validation	X	
	Qlarant Quality Solutions, Inc.	Annual Technical Report	X	
	Qlarant Quality Solutions, Inc.	Provider Surveys to Assess 24/7 Access		X
	Qlarant Quality Solutions, Inc.	Encounter Data Validation		X
	Qlarant Quality Solutions, Inc.	Focus Studies on Quality of Care		X
	Qlarant Quality Solutions, Inc.	Network Adequacy Validation	X	

2. **Assurances For PAHP program.**

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

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

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

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees

have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

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

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

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

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

Please check any processes or procedures listed below that the State uses in the

process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

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

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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; and
- Enrollee-initiated requests for phone conversations with MCO staff.

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

- Mailings in response to enrollee requests;
- Gifts to enrollees based on specific health events unrelated to enrollment (e.g., baby T-shirt showing immunization schedule);
- Marketing materials to potential enrollees;
- Enrollee materials (Provider Directories, Enrollee Handbooks, Enrollee ID cards, etc.);
- Information to be used on the MCO's Website or the Internet;
- Print media; and
- Television and radio storyboards or scripts;
- Survey former or current enrollees.

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

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

1. _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.

MCOs may provide promotional gifts valued under $15 per individual gift and no more than a cumulative annual value of $75 to potential enrollees. The MCO may not provide gifts to providers to distribute to potential enrollees, unless such gifts are placed in the providers' office common areas and are available to all patients.

After enrollment, the MCO may provide to enrollees pertinent items (e.g., magnet with immunization schedule) that have been pre-approved by the State prior to distribution. MCOs may only issue gift cards to enrollees 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, enrollee surveys, etc.) unrelated to enrollment. 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 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. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The MCO is required to translate marketing materials in any prevalent non-English languages identified by the State. The State considers any language spoken by five percent (5%) or more of the population to be significant. At the time of waiver renewal submission, no prevalent non-English languages are spoken by the population.

On an ongoing basis, the State reviews eligibility reports, which records demographic information such as primary language at the time of the application, to determine prevalent languages. Within ninety (90) calendar days of notification from DoHS, the MCO will make written materials available in prevalent non-English languages.

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. X The languages comprise all languages in the service area spoken by approximately five (5) percent or more of the population.

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**

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

The MCO is required to translate written materials in any prevalent non-English languages identified by the State. The State considers any language spoken by five percent (5%) or more of the population to be significant. At the time of waiver renewal submission, no prevalent non-English languages are spoken by the population.

Written enrollee materials must include taglines in the prevalent non-English languages.

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. _X_ The languages spoken by approximately five (5) percent or

more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

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

The MCO must provide oral interpretation services available in all non-English languages to all enrollees and potential enrollees free of charge on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. The MCO must also provide audiotapes for the illiterate upon request.

The MCO must notify enrollees that oral interpretation services are available for any language. Written materials must include taglines whenever taglines are necessary to ensure meaningful access by limited English proficiency (LEP) individuals to a covered program or activity and be in the prevalent non-English languages and large print (in a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and the toll-free and TYY/TDY telephone number of the MCOs.

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

The MCO must maintain an Enrollee Services Department to assist enrollees in obtaining Medicaid and socially necessary services (SNS) covered services. The Enrollee Services Department, at the minimum, must be accessible during regular business hours, at least for nine (9) hours a day and through a toll-free phone number. The Enrollee Services Department must work with Medicaid enrollees, CPS workers, Adoptive and Foster Care parents, and providers to handle questions and complaints and to facilitate the provision of services. The MCO must provide training to all call center staff on all aspects relating to the Medicaid program, including but not limited to all grievances and appeals procedures.

The MCO must notify an enrollee of the availability of the enrollee handbook within five (5) business days of official enrollment notification to the MCO. The MCO must also ensure that the enrollees, their families, and CPS workers have access to the most current and accurate information concerning the MCO's network provider participation.

The State also requires the MCO to develop and maintain a public website to provide general information about West Virginia's MHP program, the provider network, customer services, and the complaints and appeals process for enrollees, foster families, adoptive families, CPS workers, and providers.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X_ State

The DoHS office makes available to all potential enrollees information about the managed care programs and options through the Your Guide to Medicaid. The Your Guide to Medicaid can be accessed at https://dhhr.wv.gov/bms/BMSPUB/Documents/Medicaid_101_Manual_2021_Edition.pdf

___ contractor (please specify) ________

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

c. Enrollee Information

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

(i) _X_ the State

The DoHS office makes available to all enrollees information about the managed care programs and options through the Your Guide to Medicaid. The Your Guide to Medicaid can be accessed at https://dhhr.wv.gov/bms/BMSPUB/Documents/Medicaid_101_Manual_2021_Edition.pdf

(ii) State contractor (please specify):______

(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

The State requires the MCO to develop and maintain a public website to provide general information about West Virginia's MHP program, the provider network, customer services, and the complaints and appeals process for enrollees, foster families, adoptive families, CPS workers, and providers. The MCO must ensure that the enrollees, their families, and CPS workers have access to the most current and accurate information concerning the MCO's network provider participation.

The MCO must provide enrollees a copy of its provider directory, upon request within five (5) business days. The provider directory must include the provider names and group affiliations, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers. The directory must also include provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office; identification of providers that are not accepting new patients; provider specialties (as appropriate); and whether the provider's office/facility has accommodations for people who have physical disabilities, including offices, exam room(s), and equipment.

C. Enrollment and Disenrollment

1. **Assuranc<u>es</u>.**

_X_ 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:

For initial enrollment of children in foster care, adoption assistance, and youth formerly in foster care up to age twenty-six (26), the Department issues a notice to all eligible enrollees regarding their eligibility and transition to managed care. This notice provides the following:

- Information about Medicaid benefits.
- Explanation that the enrollee will be auto-assigned to the MHP MCO.
- Information about the right to opt out of managed care at any time between the original date of the notice or at any point after enrollment with the MCO.
- Instructions for contacting the BMS Member Services Division via the fiscal agent to request to disenroll from the MHP MCO and be served through the FFS delivery system.

Changes in enrollment are effective the first (1st) day of the next month depending on the time of the month in which the request is received (e.g., after the managed care cut-off date in the month, the change would not be effective until the first (1st) day of the following month).

For children eligible through the CSED waiver, as a condition of application, the enrollee is notified at the time the waiver slot is approved that the specialized MCO delivers the CSED services and the child will be enrolled in that specialized MCO. Many individuals who receive waiver slots are already enrolled in managed care under the State's Mountain Health Trust (MHT) program, and are transitioned from their current MCO to the specialized MHP MCO.

On May 14, 2019, the U.S. Department of Justice and the WV Department of Health and Human Resources (now referred to as the Department of Human Services) entered into an agreement to reflect DoHS's commitment to improving West Virginia's children's mental health system to ensure that children can receive appropriate mental health and social services in their homes, schools, communities, efficiently and effectively. Implementation of the concurrent 1915(c) CSED waiver and engaging children in appropriate service utilization will help to address some elements of the agreement. .

A copy of the agreement can be accessed at: https://dhhr.wv.gov/News/Documents/2019.05.14%20DOJ%20Agreement.pdf. DoHS's agreement with the DOJ is independent of this waiver. There are no DOJ services as part of the agreement; therefore there are no expenditures for DOJ services under this waiver.

The Department current holds quarterly Child Welfare Collaborative meetings that are open to the public in which the State shares information about the MHP MCO model, as well as other child welfare reform initiatives.

When there are changes related to the MHP program, local DoHS offices are provided relevant updates and trainings. In-service trainings are scheduled with local DoHS staff including BSS staff as needed to ensure they understand the changes.

The MCO is also required to create a voluntary advisory group of foster, adoptive, and kinship parents as well as parents of children with an SED, which must meet every six (6) months, to discuss issues they are encountering with the MCO and recommend solutions. The MCO must report to the Department as requested on the recommendations of the advisory group and address how and why procedures have or have not changed based on those recommendations. This report must be submitted by the Department to the Secretary and the Legislative Oversight Commission on Health and Human Resources Accountability and the public in a timely fashion and must be available on the MCO's MHP website.

b. **Administration of Enrollment Process**.

_X_ State staff conducts the enrollment process.

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

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

Broker name: __________________

Please list the functions that the contractor will perform:

___ choice counseling
___ enrollment
___ other (please describe):

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

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

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

_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.):

Youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the state of West Virginia are eligible for MHP enrollment statewide effective at the start of the renewal waiver period.

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

i. ___ Potential enrollees will have____days/month(s) to choose a plan.
ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

_X_ The State **automatically enrolls** beneficiaries

_X_ 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)

_X_ 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: statewide.

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

_X_ 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:

As described in earlier sections of this waiver application, foster care and adoption assistance populations are enrolled automatically into the specialized MCO using day one (1) auto-assignment logic, but may opt out of managed care and request to receive services through FFS Medicaid. The CSED waiver population must remain enrolled in the specialized MCO to retain eligibility for the CSED waiver and access to services administered solely under the specialized MCO.

_X_ 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.

Children in foster care or adoption assistance or eligible youth previously in foster care up to age twenty-six (26) who lose eligibility for any length of time and then regain eligibility are auto-assigned to the MHP MCO. This process will follow the initial enrollment process and the family of the child in adoption assistance, the CPS worker of the child in foster care, or the enrollee as appropriate, may choose to disenroll and obtain services through FFS.

For the CSED waiver population, if a child loses eligibility for the waiver, he or she must reapply for waiver coverage through KEPRO. Enrollees who remain Medicaid eligible, but are ineligible for the waiver, will transition to the MHT program under a TANF category.

Both foster care and CSED waiver populations will remain continuously enrolled in the specialized MCO unless their eligibility status is amended.

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:

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

- Continuous placement in a nursing facility, State institution or intermediate care facility for intellectual/ developmental disabilities for more than thirty (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 beneficiary was enrolled 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 may not request disenrollment because of an enrollee's attempt to exercise his or her rights under the grievance system. The MCO must assure the Department 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. The MCO submits a monthly report to the Department that identifies enrollees the vendor feels qualify for disenrollment which is reviewed by State staff prior to any disenrollment occurring. Disenrollment is a manual process, which will be applicable to all MHP populations prior to any action occurring.

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. **<u>Assurances</u>.**

_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. **<u>Details for MCO or PIHP programs</u>**.

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 <u>60</u> days (between 20 and 90).

_X_ The State's timeframe within which an enrollee must file a **grievance** is ___ days. In accordance with federal regulations, an enrollee may file a grievance at any time.

c. **Special Needs**

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

The State has an Ombudsman for this program as is required per legislative mandate West Virginia *Code* §49-9-101 et seq. The Ombudsman is independent of BMS and is an office within the DoHS Office of the Inspector General. The Ombudsman position is designed to advocate for the rights of children and parents within the foster system and can be engaged at any time by the enrollee or family.

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.

The MCO is required provide reasonable assistance in completing the enrollee grievance and appeal procedure, including but not limited to completing forms, auxiliary aids and services, and toll-free phone numbers with adequate TYY/TDD and interpreter capability as specified by the MCO.

The MCO is also required to establish and maintain a process for the review and resolution of requests for an expedited appeals process regarding any denial, termination, or reduction of Medicaid covered services, which could seriously jeopardize the enrollee's health and well-being. This includes an appeal regarding any service related to an enrollee's formal treatment plan as developed by the MCO and PCP.

The State also requires reporting by the MCO of grievances, appeals, overturns, upholds, etc. The State reviews this data for trends and excessive denial rates that can then be addressed with the MCO to determine operational changes or education that may need to

occur to ensure access to services that are required under both the 1915(b) and 1915(c) waivers.

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

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

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

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

- ___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.
- ___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: ______ (please specify for each type of request for review)

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

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

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

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

- ___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

The prohibited relationships are:

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

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

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

2. **Assurances For MCO or PIHP programs**

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

_X_ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on 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	Grievances	Timely Access	PCP/ Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication							X	X	X	X	X	X
Accreditation for Participation												X
Consumer Self Report Data	X	X	X		X		X	X	X	X	X	
Data Analysis (nonclaims)	X		X	X		X	X	X		X	X	X
Enrollee Hotlines	X	X	X		X							X
Focused Studies					X	X	X		X			
Geographic mapping							X	X				
Independent Assessment	X	X	X	X	X	X	X	X	X	X	X	X
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy Assurance by Plan							X	X			X	
Ombudsman	X		X		X	X					X	
On-Site Review				X	X	X	X	X	X	X		X

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

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

_X_ NCQA
____ JCAHO
____ AAAHC
____ Other (please describe)

A new MCO must apply for NCQA accreditation no later than nine (9) months from its operational start date in the MHP program. The MCO is required to keep current NCQA accreditation for its Medicaid lines of business and submit accreditation status reports to BMS for review and the EQRO includes information about status in the Annual Technical Report.

c. _X_ Consumer Self-Report data

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

Consumer Assessment of Health Plans Survey® (CAHPS®)

Responsible Party: Qlarant

Description:

The MCO is required to annually conduct child (and adult as needed for the enrollee population) enrollee satisfaction surveys using the latest version of the CAHPS®. The survey rates enrollee's experience of care and services and includes questions regarding choices of PCPs, availability of appointments, distance to PCP offices, referrals to specialists, ability to access specialty services, and enrollee's knowledge about how to obtain health care services.

The MCO is required to use CAHPS® survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Concurrent with submission of the analysis of survey results, the MCO submits an action plan to BMS. The action plan includes implementation steps, a timeline for completion, and any other elements specified by BMS. Along with the action plan, the MCO submits an evaluation describing the effectiveness of the previous year's interventions. After the first submission, the MCO submits updates on progress in implementing the action plan forty-five (45) days after the end of each quarter. The MCO submits CAHPS® report results to the State's EQRO, Qlarant, annually. Qlarant reviews results, compares performance to benchmarks (as applicable) and reports findings in the External Quality Review Annual Technical Report.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: MCOs must use CAHPS® survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Data informs areas including choice, information to beneficiaries, timely access, PCP and specialist capacity, coordination and continuity, and provider selection.

d. _X_ Data Analysis (non-claims)

_X_ Denials of referral requests

____ Disenrollment requests by enrollee

  _X_ From plan

  ____ From PCP within Plan

_X_ Grievances and appeals data

_X_ PCP termination rates and reasons

_X_ Other (please describe) – Periodic MCO reporting

Grievances and Appeals

Responsible Party: Qlarant

Description:

All formal and informal grievances received by the MCO are categorized into one of five areas:

- Access
- Attitude/service
- Billing/financial
- Quality of cared
- Quality of practitioner office site

The MCO also reports the number of appeals. A summary of these grievances and appeals is provided to the State on a quarterly basis. The MCO separately tracks and reports on grievances and appeals filed for medical (including vision), behavioral health, dental services, and pharmacy or filed by or on behalf of children with special health care needs (CSHCN).

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: Grievance, denials, and appeals data inform program integrity and quality of care. The State and MCOs monitor where participants experience issues that need to be elevated.

Denials of Referral Requests

Responsible Party: Qlarant

Description: The State and EQRO monitor MCO denials volume and frequency.

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: Data analysis of denials for referral requests provides insight into timeliness of care, coverage and authorizations and PCP and specialist capacity. MCOs report volume of denials in the following categories: not a covered benefit/benefit exhausted, not medically necessary, provider out of network, and systems/program issues.

PCP Termination Rates and Reasons

Responsible Party: MCO

Description:

Each quarter, the MCO must submit a list of all PCPs with each PCP's panel size at the beginning and end of each quarter, the number of providers with open closed panels, and the date of any PCP additions or terminations from the network.

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: By monitoring the termination rate of PCPs, the State provides oversight of

timeliness and access to care, PCP capacity and quality of care.

Periodic MCO Reporting

Responsible Party: MCO

Description:

The MCO must provide the State with periodic reports on a variety of performance areas, including administrative, financial, utilization, quality and satisfaction, enrollee 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

Responsible Party: MCO

Description:

In accordance with 42 CFR §438.68(b), the MCO must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. Annually, the MCO must submit to BMS a listing all providers and facilities in the MCO's network. 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. The MCOs must also submit a template, which includes the provider-to-enrollee ratio for PCPs and OB/GYNs.

Financial data

Responsible Party: MCO

Description:

Annually, on or before March 1st of each year, the MCO must submit audited financial statements for the previous year. The MCO must also submit copies of its quarterly and annual Department of Insurance reports, as well as any revisions. The 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, the MCO must submit Medicaid-specific financial statements and information on third party liability collections. The MCO is also required to submit a summary of any claims paid outside of the encounter data and sub-capitation arrangements.

Utilization

Responsible Party: MCO

Description:

The MCO must submit utilization information for enrollees to the State quarterly in standard format, including:

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

In addition, the MCO must submit separate quarterly reports on the number of PCP visits within ninety (90) days of enrollment, number of children receiving EPSDT services, and the number of ER visits among enrollees.

Encounter data

Responsible Party: MCO

Description:

The MCO submits encounter data to the State on a monthly basis, including contractor data. The MCO is 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. Frequency: Monthly, quarterly, annually, or at a frequency determined by the State

How the Activity Yields Information on the Areas Being Monitored: Periodic MCO reporting providers monitoring over program integrity and data accuracy.

e. _X_ Enrollee Hotlines operated by State

Responsible Party: MCO
Description:

The Department provides enrollment information to the MCO specialized managed care program. The MCO has an Enrollee Services Department that operates a toll-free number for enrollees and their representatives to call for support. The State will monitor the activity of the Enrollee Services Department to ensure enrollee needs are being addressed timely and professionally.

Frequency: Monthly

How the Activity Yields Information on the Areas Being Monitored: The reporting helps the State monitor enrollment and disenrollment and grievances, as well as performance of the toll-free enrollee services phone line.

f. _X_ 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).

Responsible Party: Qlarant

Description:

The EQRO conducts focus studies based on identified areas of study determined jointly with the State. Results of these studies are included in Annual Technical Reports.

Frequency: Based on study determinations with the State.

How the Activity Yields Information on the Areas Being Monitored: Conducting studies of potential issue areas allows for detailed analysis and validation of data or activities to determine extent of issue and need for corrective action.

Responsible Party: MCO

Description:

The MCO must conduct at least six (6) focus groups throughout each year with youth, families and foster parents who reside in the community and utilize socially necessary services (SNS). The focus groups must target, at a minimum, the following six (6) areas:

- Access
- Service Delivery
- Gaps in Support Systems
- Engagement with System Staff
- Cultural Competency
- Consumer Knowledge of Services and Supports

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: The focus groups provide the Department with feedback on where services are most impactful, so programmatic changes may be made to improve the overall health of the program.

g. _X__ Geographic mapping of provider network

Responsible Party: Myers and Stauffer

Description:

The State evaluates geographic mapping analyses of existing MCO provider networks on an annual basis to ensure the network has adequate geographical coverage for all provider locations within each county or within the county border. Analysis of MCO provider networks at the time of geographic mapping demonstrate whether the networks provide geographic access within the established travel time and distance standards.

Frequency: Annually or ad hoc

How the Activity Yields Information on the Areas Being Monitored: Geographic mapping provides oversight of provider network capacity and access for applicable provider specialties.

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

Responsible Party: West Virginia University (WVU)

Description: WVU conducted an independent assessment during the prior waiver period. Additionally, this waiver renewal request includes WVU's second independent assessment report for the current waiver period.

Frequency: As required by CMS

How the Activity Yields Information on the Areas Being Monitored: The independent assessments assess quality, access, and cost-effectiveness. BMS reviews findings and recommendations for potential programmatic changes.

i. ____ Measurement of any disparities by racial or ethnic groups

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

Responsible Party: The MCO and the State

Description:

The MCO contract requires the MCO to establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. The State has set minimum standards for the MCO's provider network. However, the MCO must ensure access to all services included in the MCO benefits package, even where a standard for the specialty type has not been defined. The provider network standards include provider-to-enrollee ratios and travel time and distance. The provider-to-enrollee ratios

ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers. Together, these standards ensure medical services are accessible throughout the state. The MCO must submit documentation assuring network adequacy at the following times:

- Annually
- Prior to enrolling a new population
- Prior to implementing a new benefit
- On an ongoing basis through quarterly reporting
- Immediately at any time there has been a significant change in the existing provider network that affects access and capacity.

Networks must be comprised of hospitals, PCPs, specialty care, behavioral health, and Substance Use Disorder (SUD) 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 FFS. The MCO is required to submit its full provider network, including all PCPs, specialists, 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 FFS 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 the MCO's provider network in each county to ensure it meets appropriate access standards. BMS also reviews the 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.

The MCO must also submit detailed network information on an annual basis, to ensure that its network continues to be adequate and that access standards continue to be met. The State requires the MCO to report PCP-to-enrollee ratios and PCP panel sizes. These reports are reviewed to determine if there is sufficient capacity to serve enrollees. Any significant network changes, such as PCP termination affecting many enrollees, must be reported to the State immediately, along with a description of how the enrollees 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.

Frequency: Quarterly / Annually

How the Activity Yields Information on the Areas Being Monitored: Geographic mapping providers allows the State to monitor timely access and PCP / Specialist capability and quality of care.

k. _X_ Ombudsman

Responsible Party: State

Description:

In accordance with West Virginia *Code* §49-9-101 et seq, the program will have a dedicated Ombudsman who will be housed within the West Virginia Office of the Inspector General. In addition, the MCO is required to have a Medicaid Member Advocate to assist enrollees with filing grievances and addressing any other concerns.

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored:
BMS' partnership with the Ombudsman Office allows the State to monitor provider choice, enrollment / disenrollment, information to beneficiaries, grievances, and provider selection.

l. _X_ On-site review
Responsible Party: Qlarant

Description:

The State's EQRO conducts an annual on-site review of the MCO's administrative and operational systems to ensure that the MCO has the appropriate structure in place to meet all program requirements.
The Systems Performance Review (SPR) performance standards used to assess MCO operational systems include the BMS/ MCO contract requirements, standards outlined in 42 CFR §438 (Subparts A, B, C, D, E, F, and H of the Final Rule), and guidelines from other quality assurance accrediting bodies such as NCQA, as applicable. The final standards are reviewed and approved by BMS.
The on-site systems performance review evaluates the following administrative and operational areas to ensure quality, timely, and accessible of healthcare services are provided to enrollees:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System
- Subpart H §438.608: Program Integrity Requirements Under the Contract

Review of standards is based on the following three-year schedule ensuring a comprehensive review within the CMS-mandated timeframe.

Three-Year SPR Schedule

Standard	Year 1	Year 2*	Year 3
§438.10 Information Requirements			✓
§438.56 Disenrollment Requirements and Limitations			✓
§438.100 - §438.114 Enrollee Rights and Protections			✓
§438.206 - §438.242 MCO Standards	✓		
§438.330 Quality Assessment and Performance Improvement Program		✓	
§438.402 - §438.424 Grievance and Appeal System		✓	
§438.608 Program Integrity Requirements Under the Contract	✓		

*Year 2 standards were evaluated in 2022 for Measure Year 2021 compliance.

The EQRO conducts an interactive SPR process with the MCO in three (3) phases: pre-site, on-site, and post-site.

- Pre-site phase: The EQRO reviews documentation submitted by the MCO such as internal policies, procedures, enrollee handbooks, provider handbooks, newsletters, meeting minutes, access and availability monitoring reports, and other documentation that support compliance with the standards under review.
- On-site phase: The EQRO conducts the on-site review at the MCO's corporate offices and includes interviews with key MCO personnel, records reviews, and submission of additional documentation to confirm operational compliance with all performance standards. Please refer to the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.
- Post-Site phase: MCOs are provided with preliminary findings and allowed an opportunity to respond with additional evidence of compliance, if available.

Frequency: Annual

How the Activity Yields Information on the Areas Being Monitored: On-site EQRO reviews provide hands on oversight for program integrity, information to beneficiaries, grievances, timely access, PCP / Specialty capacity, coordination / continuity, coverage / authorization, and quality of care. MCO systems are essential to operating the managed care program, this activity monitors program integrity, information to beneficiaries, grievances, timely access, PCP / Specialty capacity, coordination /

continuity, coverage / authorization, and quality of care.

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

X Clinical

X Non-clinical

Responsible Party: MCOs with review by Qlarant

Description:

The MCOs must conduct performance improvement projects (PIPs) 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 PIPs 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
- 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
- Effectiveness of communications with enrollees

The MCOs submit quarterly status updates and annual reports to the EQRO. MCOs complete a data and barrier analysis and identify follow-up activities for each PIP submission. MCOs use Qlarant reporting tools and worksheets to report their PIPs. Qlarant provides MCO- specific technical assistance, as requested. Qlarant conducts an annual review of each MCO's indicated performance improvement projects utilizing the CMS protocol, Validation of Performance Improvement Projects. An annual report is completed for each MCO for BMS summarizing results and providing recommendations for improvement. Please see the State Strategy for

Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Frequency: Quarterly Review and Annual Validation
How the Activity Yields Information on the Areas Being Monitored: While some PIPs are mandated by the State, the PIPs self-selected by the plans may vary and provide insight into areas such as the following: Information to Beneficiaries, Timely Access, Coordination and Continuity of Coverage / Authorization, and Quality of Care.

n. _X_ Performance measures
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
Responsible Party: Qlarant

Description: The EQRO evaluates performance measures to include, but are not limited to:

- 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 program, the MCO is required to conduct and report a variety of performance measures, including from the Healthcare Effectiveness Data and Information Set (HEDIS®), and CMS Core Set of Children Health Care Quality Measures for Medicaid and CHIP. The State's EQRO will validate these performance measures annually, in order to evaluate the accuracy of the measures and determine the extent to which the MCO followed the specifications. Please see the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Frequency: Annual

How the Activity Yields Information on the Areas Being Monitored: The State collects a variety of performance measures through its periodic reporting and EQRO process covering several key monitoring areas process and outcomes measures. These measures are compared to national

benchmarks to gauge performance and identify gaps in care.

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. _X_ Test 24 hours/7 days a week PCP availability

Responsible Party: Qlarant

Description: Confirm provider compliance with 24/7 access requirement.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Monitoring 24/7 access allows the State to monitor timely access and quality of care.

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

Responsible Party: Myers and Stauffer LC

Description: The State collects data regarding utilization of services from the MCO.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Monitoring utilization within the program provides the State insights into program integrity, timely access, coordination / continuity, coverage / authorization, and quality of care.

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.

_X_ 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.
- _X_ 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:
_X_ Yes
____ No. Please explain:

Summary of results: Accreditations are included in the EQROs Annual Technical Report and posted on the BMS website.

MCO	NCQA Health Plan Accreditation	NCQA Health Plan Rating	Other NCQA Accreditations, Certifications, and Distinctions	Next NCQA Review Date
ABHWV	Accredited	4.0 out of 5 Stars	Electronic Clinical Data	6/24/25

Report available at:
https://dhhr.wv.gov/bms/Members/Managed%20Care/Documents/Reports/Quality%20Reports/WV%202022%20ATR_508.pdf

Problems identified: N/A

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:
_X_ Yes
____ No. Please explain:

Summary of results:

CAHPS® Survey:

The West Virginia Medicaid MCO averages performed better than national average benchmarks in seventy-two (72) percent of select CAHPS® survey measures. The MY 2021 MHP ABHWV rates met or exceeded national average benchmarks in nine (9) of thirteen (13), or sixty-nine percent (69%), PMV measures in which benchmarking was completed. The following six (6) measures demonstrated commendable performance and met or exceeded the 75th percentile benchmarks:

- Annual Dental Visits: 2-3 Yrs
- Child and Adolescent Well-Care Visits: 12-17 Yrs

- Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception
- Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days
- Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days
- Percentage of Eligible (Children) that Received Preventive Dental Services

West Virginia 2022 CAHPS® (MY 2021) Measures

Overall Survey Findings for Member Experience - Medicaid Population	MCO AVG %	
	Adult MCO	Child MCO
Getting Needed Care Composite (% Always or Usually)	85.66	93.94
Getting Care Quickly Composite (% Always or Usually)	85.68	94.90
How Well Doctors Communicate Composite (% Always or Usually)	94.71	96.96
Customer Service Composite (% Always or Usually)	97.40	95.76

Problems identified: N/A

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

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

Consumer Focus Groups:

In Q4 2022, the MCO held six (6) focus group meetings comprised of key stakeholders to discuss common themes in the MHP population: Member Advisory Council (1), Socially Necessary Services (SNS) Focus Group (2), Residential Treatment Facility (RTF) Focus Group (2), and a Grandfamilies Group (1). The focus groups are comprised of foster parents, kinship caregivers, adoption, biological parents, and biological parents of system-involved youth receiving SNS services, youth living in RTFs and their families, and Grandparents caring for their grandchildren. Focus groups have centered on information sharing, cooperation, collaboration, and services.

Problems identified: N/A

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:
_X_ Yes
____ No. Please explain:

Summary of results:

Disenrollment

Enrollees may choose to opt out of the MHP program (with exception of the CSED waiver population). Opt out rates are low, with only twelve (12) enrollees opting out in the first three (3) quarters of FY23.

For the CSED waiver population, children who lose eligibility for the waiver must reapply for waiver coverage through KEPRO. Enrollees who remain Medicaid eligible but lose waiver eligibility will transition to the MHT program under a TANF category.

Both foster care and CSED waiver populations will remain continuously enrolled in the specialized MCO unless their eligibility status is amended.

Grievances, Denials, and Appeals

The MCO submits grievance, denial, and appeal "universes" to Qlarant on a quarterly basis. Qlarant selects a random sample of records for each category and notifies the MCO to provide the full records for review and validation activities.

Qlarant's 2022 focused study activities centered on an evaluation of enrollee grievances, pre-service denials, and appeals received during the state fiscal year (SFY) 2022 (July 1, 2021-June 30, 2022). The MCO is expected to comply with 42 CFR 438.400-438.424, the Grievance and Appeal System Standard. This standard includes requirements for the following elements:

- §438.404 - Timely and adequate notice of adverse benefit determination
- §438.406 - Handling of grievances and appeals
- §438.408 - Resolution and notification: grievances and appeals
- §438.410 - Expedited resolution of appeals

Qlarant examined records and evaluated the following:

- MCO compliance with federal and state requirements to ensure the MCO provided timely acknowledgement and resolution notification.
- Denials, or adverse determination records, to assess compliance with timely notification of decisions and required letter content such as communication of an enrollee's right to file an appeal and procedures on how to do so.
- Appeal records to ensure the MCO provided timely enrollee acknowledgement and resolution notification and required letter content such as communication of an enrollee's right to request a state fair hearing and procedures on how to make such request.

The table below includes MHP ABHWV grievance, denial, and appeal compliance results for SFY 2022.

MHP ABHWV Grievance, Denial, and Appeal Compliance (SFY 2022)

Category	MHP ABHWV Compliance
Grievances	100%
Denials	100%
Appeals	96%

Periodic MCO Reporting

The State reviews periodic MCO reports to monitor quality, access, and performance on an ongoing basis. Results for each performance area designated in Section B: Monitoring Plan are as follows:

PCP Termination Rates and Reasons: The MCO provides provider termination notices as part of its quarterly reporting, including the reason for termination.

Provider network: In Q3 2022, the MCO enrolled 1,143 enrollees and auto-assigned 843 to a PCP. Additional information of the provider network can be found in the network adequacy monitoring activity.

Financial data: The MCO reported increased total revenue from Q2 to Q3 in FY23 by approximately 5.69%.

Utilization: Quarterly utilization metrics can be found under the Utilization Review monitoring activity.

Encounter: The MCO submits monthly encounter data verification forms to certify the integrity of the encounter data and provider proper recourse for all stakeholders.

Problems identified: N/A

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:
_X_ Yes
____ No. Please explain:

Summary of results:

The MCO's call center rates for the Q4 2022 are provided below. BMS monitored calls, answered, and addressed them within the standards set by the State. No issues were detected for calls regarding medical, behavioral, or dental benefits.

Member Functions (including Medical and Behavioral)

Member Services	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
Total member calls	725	426	487	1,638
Total calls answered	722	424	486	1,632
Member services line average answer time (seconds)	5	5	5	5
Member services call answer timeliness	97.1%	95.5%	95.7%	96.3%

Member Services	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
(percentage)				
Average hold time (seconds)	34	65	50	47
Total abandoned calls	3	2	1	6
Average call abandonment rate	0.4%	0.5%	0.2%	0
Total PCP change requests	122	95	62	279
Total requests for materials in alternate forms	-	-	-	-

Member Functions (Dental)

Member Services	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
Total member calls	75	41	47	163
Total calls answered	75	41	47	163
Member services line average answer time (seconds)	1	1	1	1
Member services call answer timeliness (percentage)	100.0%	100.0%	100.0%	100.0%
Average hold time (seconds)	115	44	63	82
Total abandoned calls	-	-	-	-
Average call abandonment rate	0.0%	0.0%	0.0%	0.0%
Total PCP change requests	-	-	-	-
Total requests for materials in alternate forms	-	-	-	-

Problems identified: N/A

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

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

Strategy: Focused Studies

Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:

Summary of results:

Qlarant performs a Grievance, Appeals, Denials focus study as described earlier in this section.

Problems identified: N/A

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:
_X_ Yes
____ No. Please explain:

Summary of results:

See summary under below strategy for geographic mapping.

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:
_X_ Yes
____ No. Please explain:

Summary of results:

The State re-evaluates MCO network adequacy annually. In 2021, the MCO network was re-evaluated to ensure access standards are met. The MCO was required to submit geographic data maps demonstrating the availability of multiple provider types. In addition, the MCO submitted data on enrollee-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 the MCO met required standards.

Problems identified: See findings in the Network Adequacy Assurance Submitted by the Plan later in this section.

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

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

Strategy: Independent Assessment

Confirmation it was conducted as described:
_X_ Yes
__ No. Please explain:

Summary of results:

See West Virginia University's Independent Assessment report submitted with this waiver renewal application for results for the current waiver period.

In addition, WV DHHR (now referred to as DoHS) contracted West Virginia University (WVU) Office of Health Affairs to conduct an Independent Assessment (IA) of the first nine (9) months of the MHP program (March 1, 2020 – November 30, 2020) and summary findings related to that initial assessment are presented below.

Access to Care

The IA found that MHP meets the minimum CMS requirements and does not substantially impair enrollee's access to service. More specifically, based on the available information at the time of the IA, WVU found that processes aimed at ensuring that provider directories and marketing materials are clear, easy-to-understand, are accessible to people with disabilities, and do not mislead or defraud enrollees, are comprehensive and contribute to enrollee access. Enrollment procedures for enrollees were found to be comprehensive and efficient and indicate regular collaboration between WV DoHS, Aetna, and the then contractor, Gainwell.

Additionally, the process of early and intensive outreach to new enrollees by the MCO exceeds contract requirements and are supportive of enrollee access. Aetna leverages its existing MHT provider network to ensure MHP enrollees have access to a range of specialty and facility service providers. The MCO has leveraged strong community relationships to build a network of over 11,000 providers; over 1,000 primary care providers (PCPs); over 4,000 specialists including over 500 behavioral health specialists; over 80 hospitals; and all FQHCs and rural health clinics in WV and surrounding areas. As of November 2020, the MCO confirmed twenty-three (23) active CSED waiver providers in the network to address populations with particularly complex behavioral health needs that qualify for CSED waiver services.

Quality of Care

The elements included in the IA were a review of clinical utilization patterns, the grievance and appeals process, and enrollee, provider, and subcontractor satisfaction with MHP.

Based on the information available, the IA noted that the WV DoHS and Aetna are meeting the standards to track and monitor over-/under- utilization of services. Due to the short experience of the MHP program at the time of the IA, analysis of service utilization was not possible. However, the WV DoHS and Aetna indicated that there were no challenges related to utilization at the time of the IA. For the period reviewed, Aetna reported they did not observe indications of under-utilization and over-utilization of services, with the number of services utilized by MHP enrollees.

Additionally, the processes established by WV DoHS and the MCO to monitor grievances and appeals and enrollee and provider satisfaction was noted to be complete, meeting or exceeding CMS requirements. The results of the IA were that MHP provides a quality of care that either matches or exceeds the quality of care the population received before the waiver. The WV DoHS and Aetna both indicated that the reduced fragmentation of services due to the establishment of electronic health records and the added behavioral health services increased the quality of care for this population than what was available before the waiver program.

Cost-Effectiveness

Cost effectiveness is monitored on an ongoing basis and waiver expenditures are submitted on the federal Medicaid Expenditure reporting (CMS 64) on a quarterly basis. In addition, the

program costs are monitored via the states' established risk corridors program, annual medical loss ratio reporting, and the actuarial evaluation that occurs during the rate-setting process. When appropriate, off cycle rate adjustments are made by the state.

Problems identified: Throughout the data gathering process, WVU documented data limitations that may be addressed in future IAs. Additionally, the launch of MHP in March 2020 coincided with the COVID-19 pandemic, which caused delays in reporting and monitoring standards due to shifting priorities. For example, during the pandemic, the focus of MHP staff was to ensure that MHP enrollees had access to care. Staff resources were dedicated to making accommodations for setting up telehealth services or arranging alternative methods to access the services since enrollees had limited options to be seen in person. Comprehensive reporting of the MHP did not begin until April 2020, as captured in the assessment.

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

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

Strategy: Measurement of any disparities by racial or ethnic groups:

Confirmation it was conducted as described:
___ Yes
_X_ No. Please explain: BMS did not detect any monitoring issues in need of a focused study during the waiver period.

Summary of results: N/A

Problems identified: N/A

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:
_X_ Yes
___ No. Please explain:

Summary of results:

Consistent with 42 CFR 438.207, BMS conducts an annual provider network adequacy analysis of ABHWV, the MCO serving MHP enrollees. The MCO must contract with enough active providers that are accepting new patients within each county within the state. The MCO is considered compliant with provider network adequacy requirements, if and only if, it meets ninety percent (90%) of provider-to-enrollee ratios (for applicable provider types) and ninety percent (90%) of travel time and distance standards (for all provider types).

ABHWV met all geographic access requirements in all counties for the following provider networks: General Dentist, Behavioral Health Provider, Substance Use Disorder (SUD)

Provider, Substance Use Facility, and Essential Community Provider (ECP).

While some network gaps were identified, ABHWV pursued the appropriate exception from BMS and is attempting to locate additional providers in the area.

Problems identified: Analysis of provider network adequacy for the MCO revealed some networking gaps.

Corrective action (plan/provider level): While BMS is in the process of reviewing network adequacy exceptions and evaluating the need for corrective actions plans to address gaps in the provider network, BMS and the MCO are working to ensure that MHP enrollees have the appropriate access to care including out of network referrals.

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

Strategy: Ombudsman

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of results:

Within the first year of MHP, the Ombudsman received approximately four hundred twenty-five (425) complaints, of which approximately ninety-five percent (95%) were resolved and closed. The Ombudsman collaborated with the MCO to address approximately twenty-five (25) complaints.

The below table reflects complaints received during state fiscal year (SFY) 2022. Complaint data reflects complaints that were in a closed/concluded status as of June 30, 2022. Additionally, for the full prior SFY, complaints totaled 391.

Complaint Count by Month and Quarter												
SFY 2022	SFY2021						SFY 2022					
	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	61	52	58	38	55	45	47	47	55	62	49	54
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Total	171			138			149			165		

Problems identified: N/A

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

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

Strategy: On-site review

Confirmation it was conducted as described:
_X_ Yes

____ No. Please explain:

Summary of results:

External Quality Review Organization Activities

BMS contracts with an EQRO, Qlarant, to conduct the following three (3) mandatory EQR activities as specified in the Balanced Budget Act of 1997:

- A systems performance review (SPR) to evaluate MCO/PIHP compliance with federal Medicaid managed care regulations.
- Validation of performance improvement projects conducted by MCO/PIHP.
- Validation of performance measures produced by MCO/PIHP.

Systems Performance Review (SPR)

The MCO is required to achieve full compliance for all standards. If the MCO does not achieve 100% compliance, it is required to develop and implement internal corrective action plans (CAPs) to address all deficiencies identified.

Summary of results:

For Measurement Year (MY) 2021, the MCO achieved 100 percent compliance in the standards reviewed. The table below displays 2022 (MY 2021) MHP ABHWV SPR results by standard and identifies an overall weighted score.

2022 MHP ABHWV SPR Results (MY 2021 Compliance)

Standard	MHP ABHWV
§438.330 Quality Assessment and Performance Improvement Program	100%
§438.402 - §438.424: Grievance and Appeal System	100%
Overall Weighted Score	100%

Problems identified: N/A

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

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

Strategy: Performance Improvement Projects

Confirmation it was conducted as described:
_X_ Yes
__ No. Please explain:

Summary of results:

The State requires the MCO to complete three (3) performance improvement projects (PIPs). The State's EQRO, validates the MCO's chosen PIP as part of the annual external quality review using the CMS Protocol, Validating Performance Improvement Projects – A Protocol for use in Conducting Medicaid External Quality Review Activities, as a guideline in PIP review

activities.

MHP State and MCO-Selected PIPs

State Mandated PIP: Annual Dental Visits	
Performance Measure(s), Measure Steward, and Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure steward:** NCQA **Population:** Children 2-3 years of age
Aim	Will the implementation of collaborative member, provider, and MCO interventions improve Annual Dental Visit rates among children ages 2-3 and Preventive Dental Services rates among children 1-20 enrolled in the Aetna Better Health of West Virginia Mountain Health Promise program, by the end of MY 2023?
Phase	Baseline
Findings	• The MCO reported baseline rates. • The validation score was 100 percent.

State Mandated PIP: Percentage of Eligibles that Received Preventive Dental Services	
Performance Measure(s), Measure Steward, and Population	**PM 2:** Percentage of Eligibles that Received Preventive Dental Services **Measure steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age
Aim	Will the implementation of member, provider, and MCO interventions increase the rates of adolescent care, including well visits and immunizations received amongst members ages 9-21 with Aetna Better Health of West Virginia Mountain Health Promise, by the end of MY 2023?
Phase	Baseline
Findings	• The MCO reported baseline rates. • The validation score was 100 percent

MCO Selected PIP: Reducing Out-of-State Placement for Children in Foster Care	
Performance Measure(s), Measure Steward, and Population	**PM 1:** Reducing Out-of-State Placement for Children in Foster Care **Measure steward:** Homegrown measure **Population:** Child and adolescent members in foster care
Aim	Will implementation of member, provider, and MCO interventions decrease the rate of Out-of-State Placement for MHP members by the end of MY 2022?
Phase	1st Remeasurement
Findings	• ABHWV completed numerous targeted member, provider, and MCO interventions • MHP ABHWV reported its first remeasurement results for its Reducing Out-of-State Placement for Children in Foster Care measure. • The MCO achieved improvement in the PIP measure. • MHP ABHWV's validation score was 95 percent (high confidence).

Problems identified: N/A

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

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

Strategy: Performance Measure Validation

Confirmation it was conducted as described:
_X_ Yes
__ No. Please explain:

Summary of Results:

Qlarant validated state-selected performance measures during the 2022 PMV activity. Designated HEDIS®, CAHPS®, and CMS Core Set measures were used to calculate MY 2021 MHP performance.

ABHWV had appropriate systems in place to process accurate claims and encounters for the MHP program.

The MY 2021 MHP ABHWV rates met or exceeded national average benchmarks in nine (9) of thirteen (13), or sixty-nine percent (69%), PMV measures in which benchmarking was completed. The following six (6) measures demonstrated commendable performance and met or exceeded the 75th percentile benchmarks:

- Annual Dental Visits: 2-3 Yrs
- Child and Adolescent Well-Care Visits: 12-17 Yrs
- Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception
- Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days
- Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days
- Percentage of Eligible (Children) that Received Preventive Dental Services

MHP ABHWV Performance Measure Rates for MY 2021

Performance Measure	ABHWV %
Annual Dental Visit – 2-3 Yrs (ADV)^	44.10
Child and Adolescent Well-Care Visits: 12-17 Yrs (WCV)^	58.81
Child and Adolescent Well-Care Visits: 18-21 Yrs (WCV)^	28.11
Contraceptive Care – All Women Ages 15-20 LARC Method of Contraception (CCW-CH)	5.08
Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception (CCW-CH)	40.96

Performance Measure	ABHWV %
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days (CCP-CH)	5.32
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 60 Days (CCP-CH)	13.83
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days (CCP-CH)	9.57
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 60 Days (CCP-CH)	47.87
Developmental Screening in the First Three Years of Life Age 1: Eligible children who had a screening on or before their 1st birthday (DEV)	23.87
Developmental Screening in the First Three Years of Life age 2: Eligible children who had a screening on or before their 2nd birthday (DEV)	21.54
Developmental Screening in the First Three Years of Life Age 3: Eligible children who had a screening on or before their 3rd birthday (DEV)	20.49
Developmental Screening in the First Three Years of Life Total: Total number of eligible children who had a screening in the 12 months on or before their 1st, 2nd, or 3rd birthday (DEV)	21.70
Immunizations for Adolescents - Combination 2 (IMA)^	32.12
Out-of-State Placements in Foster Care	5.58
Percentage of Eligible (Children) that Received Preventive Dental Services (PDENT-CH)	53.14
Screening for Depression and Follow-Up Plan - Ages 12-17 Years (CDF-CH) ***New measure***	1.87
Sealant Receipt on Permanent First Molars - Rate 1 - At Least One Sealant (SFM-CH) ***New measure***	18.83
Sealant Receipt on Permanent First Molars - Rate 2 - All Four Molars Sealed (SFM-CH) ***New measure***	11.34

Problems identified: N/A

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

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

Strategy: Periodic Comparison of Number and Type of Medicaid Providers

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of Results:

Provider panels of the MCO are assessed on a quarterly basis and included in quarterly dashboards and network adequacy assessment. Please see network adequacy results for further information. Periodic comparison of providers is evaluated under PCP/Specialist Capacity.

Problems identified: N/A

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

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

Strategy: Profile Utilization by Provider Caseload

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of Results:

PCP Panels	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
Number of PCPs with closed panels	610	610	598	598
Number of PCPs with partially restricted panels	976	976	973	973
Number of PCPs with open panels	2559	2561	2539	2539
PCP Additions and Deletions	**Oct 2022**	**Nov 2022**	**Dec 2022**	**CY2022 Q4**
Total PCP Additions	2	1	0	3
Total PCP Deletions	3	0	37	40
Total Members Affected by Deletions	26	0	106	132

PCP to Enrollee Ratios				CY2022 Q4
PCP to Enrollee Ratio at end of quarter - All contracted PCPs				7
PCP to Enrollee Ratio at end of quarter - PCPs with assigned members				14

Problems identified: N/A

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

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

Strategy: Provider Self-Report Data

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of Results:

The provider survey data available at this time is summarized under “Strategy: Test 24.7 PCP Availability.”

Problems identified: N/A

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

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

Strategy: Test 24/7 PCP Availability

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of Results:

During Q1-Q3 2022, Qlarant completed validation activities by randomly selecting and surveying a sample of providers from each MCO's provider directory.

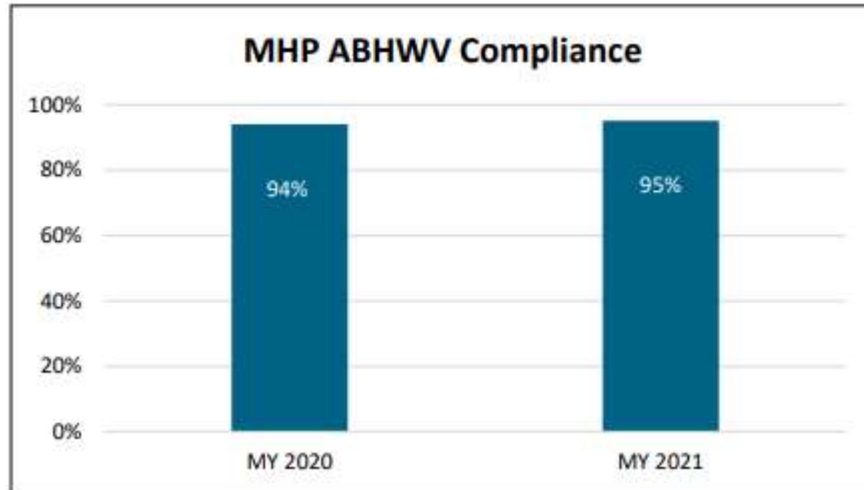
The successful contact rate for MHP ABHWV was eighty-five percent (85%). Unsuccessful contact was most frequently due to the phone number not reaching the intended provider. For successful provider contacts, the MCO demonstrated one hundred percent (100%) compliance with directing enrollees to care. A Q4 resurvey of providers not accessible during Q1-Q3, resulted in successful contact for seventy-eight percent (78%) for MHP ABHWV. Of the successfully contacted providers, the MCO achieved one hundred percent (100%) compliance with the 24/7 access requirement. Most unsuccessful surveys were due to the phone number not reaching the intended provider fifty-six percent (56%). This was followed by no answer/no automated message thirty-three percent (33%) and generic voicemail that did not identify the provider or practice eleven percent (11%).

The MCO demonstrated a positive trend in performance, improving from ninety-four percent (94%) in MY2020 to one hundred percent (100%) to MY2022 respectively.

Any PCP or behavioral health provider that was not accessible during Q1-Q3 2022 surveys were resurveyed during Q4. Prior to the resurvey, the MCO had sufficient time to follow up with each provider and remedy any issue that prevented successful contact or compliance with directing enrollees to care during nonbusiness hours and update their provider directories accordingly.

MY 2022 Resurvey Results

Providers Requiring Resurvey	
Percentage of providers not accessible during Q1-Q3 2022 and required a resurvey	15%
Resurvey Results*	
Percentage of providers successfully contacted during Q4 2022	78%
Percentage of successfully contacted providers compliant with 24/7 access requirement during Q4 2022	100%



Problems identified: N/A

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

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

Strategy: Utilization Review

Confirmation it was conducted as described:
_X_ Yes
____ No. Please explain:

Summary of results:

The MCO reported utilization metrics including admits (and admissions per 1,000 enrollees, APT), days (and days per 1,000 enrollees, DPT), visits (and visits per 1000 enrollees, VPT), length of stay, and cost for a number of categories across physical health, behavioral health, and deliveries. Q4 2022 had 93,349 member months.

The following table reports utilization metrics for Q4 2022.

Ref #	Service Category	Member Months total 93,349						
		Admits	**Days**	**Visits**	**APT**	**DPT**	**VPT**	**Avg LOS**
Physical Health, excluding Deliveries								
1	Inpatient - Facility	131	544		16.8	69.9		4.2
2	**Outpatient - Facility (Total)**			**29,760**			**3,825.6**	
3	ER - Facility			4,177			537.0	
4	Other Outpatient - Facility			10,198			1,311.0	
5	Clinic			15,385			1,977.7	
6	**Physician (Total)**			**52,859**			**6,795.0**	

Ref #	Service Category	Member Months total 93,349						
		Admits	Days	Visits	APT	DPT	VPT	Avg LOS
7	Physician - ER			5,966			766.9	
8	Physician - Inpatient			1,292			166.1	
9	Physician - Office or Home			36,229			4,657.2	
10	Physician - Outpatient			9,372			1,204.8	
11	Ambulance			447			57.5	
12	Home Health			984			126.5	
13	Dental			9,898			1,272.4	
14	All Other			15,135			1,945.6	
15	**Total Physical Health**							
Behavioral Health								
16	BH Inpatient	688	9,036		88.4	1,161.6		13.1
17	BH Outpatient			4,939			634.9	
18	BH Physician			16,297			2,095.0	
19	BH Rehab/Clinic			4,424			568.7	
20	All Other BH			8,265			1,062.5	
21	**Total Behavioral Health**							
22	**Total Non-Maternity**							
Deliveries								
23	Vaginal	32	75		4.1	9.6		2.3
24	Cesarean	7	26		0.9	3.3		3.7
25	**Total Deliveries**							
26	**TOTAL**							

Problems identified: N/A

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

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

Other:

Section D – Cost-Effectiveness

Name of Medicaid Eligibility Group	MCO PMPM or FFS
Children with Serious Emotional Disorders (CSED)	MCO
Foster Care Children	MCO
Adoption & Guardianship Assistance	MCO
Youth Formerly in Foster Care	MCO

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: Mandy Carpenter

c. Telephone Number: 304-352-4222

d. E-mail: Mandy.D.Carpenter@wv.gov

e. The State is choosing to report waiver expenditures based on
 X date of payment.
 __ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

b.___ The State makes enhanced payments to contractors or providers.

c.___ 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. X 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: $_____ per member per month fee
2.___ Second Year: $_____ per member per month fee
3.___ Third Year: $_____ per member per month fee
4.___ Fourth Year: $_____ per member per month fee

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. _ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

____

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

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____ f.____

[Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

____

For Conversion or Renewal Waivers:

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

Note that the former foster care youth MEGs were not included in the MHP waiver during R1 and R2, but will be moving to MHP effective at the start of this renewal period. Additionally, the "Foster Care Children" and "Adoption & Guardianship Assistance" MEGs were both included in the "Children & Youth" MEG in the previous waiver period.

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

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

Enrollment projections are based on waiver enrollment during SFY 2023 and trends in more recent enrollment as well as the expected additional enrollment of a small former foster care population up to twenty-six (26) years old newly eligible for the MHP waiver program at the start of the renewal waiver period. This population consisted of ninety-two (92) members on average in SFY 2023 The projected member months for this population, after their expected incorporation into MHP at the start of the renewal period, have all been allocated to the "Youth Formerly in Foster Care" MEG.

The initial R2 to P1 decrease in member months for the "Foster Care Children", "Adoption & Guardianship Assistance", and "Youth Formerly in Foster Care" MEGs are due to the continuing reversal of eligibility verification suspension related to the COVID PHE, while the P1 to P2 increase in member months is due to a return to continuing slight enrollment growth due to population changes and continued placement of children into foster care or requiring adoption and guardianship assistance due to the drug epidemic.

The CSED MEG enrollment is not expected to be materially impacted by the end of the COVID PHE eligibility verification pause. The slight increase in the CSED MEG enrollment from R2 to P1 to P2 is due to continuing interest in this waiver program and the State anticipating amending the waiver to allow for more openings based on demand.

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

The primary reason for the decrease in "Foster Care Children", "Adoption & Guardianship Assistance", and "Youth Formerly in Foster Care" member months from R2 to P1 is continuing reversal of the eligibility verification suspension and unemployment related to the COVID health emergency, while the slight increase in member months from P1 to P2 is due to the continued placement of children into foster care as a result of the drug epidemic.

CSED enrollment is estimated to increase in P1 and P2 due to the continued placement of children into foster care and continuing interest in the CSED waiver program. Based on this interest, the State anticipates amending the waiver to allow for more openings in the program.

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

R1 is State Fiscal Year SFY 2022 (July 1, 2021 through June 30, 2022) and R2 is SFY 2023 (July 1, 2022 through June 30, 2023).

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**:

Mobile response services will be included in the upcoming waiver period for all MHP enrollees instead of just for the CSED waiver population in the previous period. This change in included in the Program Adjustment applied in Appendix D5.

The new MHP former foster care MEG is very small (less than 100 enrollees) and will have access to the same services as the existing Foster Care MHP population. The PMPM state plan service costs for the former foster care population in the retrospective period and the consistent MHP administration costs have been added to the projections in Appendix D5.

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

No services were excluded from the cost-effective analysis.

The capitation costs for R1/R2 are based on actual PMPM payments made to the MCOs, while the separate FFS expenditures have been developed using the quarterly CMS-64 reporting for the separate waiver populations and additional details on the eligibility groups.

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

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

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart

below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total			
	Appendix D5 should reflect this.		*Appendix D5 should reflect this.*

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

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

b. X 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:

Enrollees will be defaulted into managed care and may actively opt out into FFS. Based on experience in other states and this program, the percentage of enrollees we anticipate opting out is not expected to materially impact the aggregate risk of the underlying population, thus no explicit adjustment for selection bias was deemed necessary.

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

1. ____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

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

Current Initial Waiver Adjustments in the preprint

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

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

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

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

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: __________. Please document how that trend was calculated:

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

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

ii.____ National or regional factors that are predictive of this waiver's

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

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

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

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

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

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

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

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

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

For each change, please report the following:

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

B. ____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______

C. ____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______

D. ____Determine adjustment for Medicare Part D dual eligibles.

E. ____Other (please describe):

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

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

For each change, please report the following:

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

B. ____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______

C. ____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______

D. ____Other (please describe):

iv. _ Changes in legislation (please describe):

For each change, please report the following:

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

B. ____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______

C. ____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______

D. ____Other (please describe):

v._ Other (please describe):

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and

Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

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

2.___ An administrative adjustment was made.

- i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
  - A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
  - B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
  - C.____ Other (please describe):
- ii.___ FFS cost increases were accounted for.
  - A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
  - B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
  - C.____Other (please describe):
- iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
  - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_______________ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
  - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above ______.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual

Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

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

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

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above ______.

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

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

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

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

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

3.___ Other (please describe):

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

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

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**
1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program.

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

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

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

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

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and method:
1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:
1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an

included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

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

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

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
   a. ___Potential Selection bias was measured in the following manner:
   b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

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

Special Note section:

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

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

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

Adjustment	Capitated Program	PCCM Program

Adjustment	Capitated Program	PCCM Program

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

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

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

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while

other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The 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: -4.3%. Please document how that trend was calculated:

   The State cost trend is based on the change in the weighted average of the MHP capitation costs in R2 (July 1, 2022 through June 30, 2023) and the weighted average of the capitation rates effective through the beginning of P1. The CSED trend rate is -11.1%, while the trend rate for the other MHP MEGs is -4.1%.

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

      The current SFY 2025 capitated ratesetting work indicates a five (5%) percent increase in costs for the foster care, adoption and guardianship assistance populations as well as a ten (10) percent increase for the CSED population from SFY 2024 to SFY 2025. The trends are based on expected changes in the SFY 2025 capitated rates. The SFY 2025 rates are developed using a regression of normalized historical SFY 2023 base data and include adjustments for changes in acuity due to the end of the Public Health Emergency (PHE).

      The SFY 2025 to SFY 2026, five percent (5%) increase is based on a review of historical state trends, CMS nationwide expenditure projections, and actuarial judgment. The trends for both years are inclusive of acuity changes, utilization changes, unit cost changes, service mix, and productivity changes.

For P1, one (1) year of the historical State cost trend was used for SFY 2023 to 2024 (since R2 was more than 3 months prior to the beginning of P1) and one (1) year of the SFY 2024 to SFY 2025 trend was used. The CSED calculation was (0.889^1)*(1.100^1)-1 = -2.2% and the calculation for the other MHP MEGs was ((0.959^1)*(1.050^1))-1 = 0.70 percent. Then, for P2, one (1) year of the SFY 2025 to SFY 2026 trend was 5 percent for all MHP MEGs.

The Congressional Budget Office (CBO) ten (10)-year PMPY budget projections for Medicaid – average federal spending on Children benefit payments per enrollee for years 2023 through 2026 indicated an approximate 6.9% increase for the P1 to P2 period. The P2 State trend is less than the national CBO trend for Children's Medicaid.

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

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

b. _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.___ 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. X An adjustment was necessary and is listed and described below:

   i. X 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. X Other (please describe): We estimate a two percent (2.0%) annual increase in cost for P1 and P2 due to expected changes in the 1115 waiver renewal, the expansion of mobile crisis services, and the understanding that additional changes may be proposed in the future. The expected new services under the 1115 waiver include: the explanation of peer recovery support services; continuity of care for justice-involved individuals with SUD; HIV/HCV community outreach and education; Quick Response Teams (QRTs); Involuntary Secure Withdrawal Management and

Stabilization (SWMS); SDOH supports for SUD members; recovery housing; supported housing; supported employment; contingency management; and expanded residential and inpatient treatment services.

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

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

iv. _ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

v. _ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

vi._ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

c. X **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-*

effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

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

2._X_ An administrative adjustment was made.

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

   ii.X_ Cost increases were accounted for.

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

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

      C.X___State Historical State Administrative Inflation. The actual trend rate used is: three percent (3%) annually. Please document how that trend was calculated: R2 to P1 twenty-four (24) months and P1 to P2 twelve (12) months at three percent (3.0%) annually.

      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 ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

1.___ No adjustment was made.
2.X This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

A small former foster care population up to twenty-six (26) years old will be added to the MHP waiver program at the start of the renewal waiver period with access to the same services as the existing Foster Care MHP population. This population is identified in the new "Youth Formerly in Foster Care" MEG. Since this MEG was not part of the MHP waiver program previously, it has not been included in any of the retrospective information in appendices D1 through D3. However, the waiver costs projections (Appendix D5) has been updated to included PMPM costs for this population to develop cost projections for the upcoming waiver renewal periods.

PMPM expenditures for the former foster care population in the retrospective period were identified and compared to the PMPM service plan costs for the oldest Foster Care enrollees under MHP to ensure reasonableness. The actual PMPM Former Foster Care costs for SFY 2023 (R2) were added to the P1 Projections for State Plan Services section of Appendix D5. Additionally, the consistent MHP administration costs for R2

was included in the Former Foster Care MEG P1 Projections for Administration Costs in Appendix D5. Then the same non-CSED state plan adjustment and program adjustments applied to the "Foster Care Children" and "Adoption & Guardianship Assistance" MEGs were applied to the new "Youth Formerly in Foster Care" MEG to develop the P1 and P2 PMPM Projection Waiver Costs for this new MEG.

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.

R2 was selected as our base period, since it was the second complete year of the initial waiver period and is more recent. R1was the first complete year of the initial waiver period.

The base period, state plan trend, state plan programmatic changes, administrative cost adjustments, and new MEG (Former Foster Care) adjustment are all described above in section D4.

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**:

   N/A

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**:

   R1 to R2: The average PMPM decreases are due to national trends, including continuing decreased pandemic related utilization.

   R2 to P1: The annualized increases tie back to the return of pre-pandemic related utilization, the expansion of 1115 related services detailed previously, and the continuing high inflationary environment.

   P1 to P2: State and national factors that are predictive of this waiver's future. The Congressional Budget Office (CBO) ten (10)-year PMPY budget projections for Medicaids – average federal spending on Children benefit payments per enrollee for years 2023 through 2026 indicated an approximate 6.9% increase for the P1 to P2 period. The annual P1 to P2 change is only slightly higher than this due to the the expansion of 1115 related services detailed previously, and the continuing high inflationary environment.

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**:

   R1 to R2: The average PMPM decreases are due to national trends, including continuing decreased pandemic related utilization.

   R2 to P1: The annualized increases tie back to the return of pre-pandemic related utilization, the expansion of 1115 related services detailed previously, and the continuing high inflationary environment.

   P1 to P2: State and national factors that are predictive of this waiver's future.

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.