Proposal for a Section 1915(b) Capitated Waiver Program

Waiver Initial Submittal

Specialized Managed Care Plan for Children and Youth

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

November 20, 2019

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations

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FACESHEET

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

The **name of the waiver program** is Specialized Managed Care Plan for Children and Youth.

Type of request. This is an:

_X_ initial request for new waiver. All sections are filled.
___ amendment request for existing waiver, which modifies
- ___ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

- __ Document is replaced in full, with changes highlighted

__ renewal request
- ___ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
- __ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is:

- ___ replaced in full
- ___ carried over from previous waiver period. The State:
  - ___ assures there are no changes in the Program Description from the previous waiver period.
  - ___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is:

__ replaced in full
___ carried over from previous waiver period. The State:
- ___ assures there are no changes in the Monitoring Plan from the previous waiver period.
- ___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Effective Dates: This waiver is requested for a period of 17 months; effective February 1, 2020 and ending June 30, 2021. (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 Jeff Wiseman and can be reached by telephone at (304) 558-6052, or fax at (304) 558-4398, or e-mail at Jeff.A.Wiseman@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, Specialized Managed Care Plan for Children and Youth, that will provide statewide physical and behavioral health managed care services for approximately 19,000 children and youth in the foster care system and individuals receiving adoption assistance[1]. This waiver request is for an initial seventeen month period beginning February 1, 2020, and ending June 30, 2021.

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. The State continues to hold Child Welfare Task Force meetings that include representation from the Secretary of the Department of Health and Human Resources' (DHHR) office, Bureau for Medical Services (BMS), Bureau for Children and Families (BCF), , and other consultants to the State. These meetings provide the State with a high level of oversight of program administration issues and promote continuous improvement in all aspects of the program (e.g., enrollment, health care delivery, external monitoring). Representatives from other State agencies also attend the meetings when necessary. These representatives raise issues of concern to their constituencies and obtain information about the program to share with their staff and beneficiaries.

[1] As of January 1, 2019

This waiver will run concurrent with the state's 1915(c) waiver for Children with Serious Emotional Disturbances (SED) and 1115 expenditure authority allowing the state to enroll the SED population into one specialized MCO.

A. Statutory Authority

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

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

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

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

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

d.___ S**ection 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.

For children in foster care and adoption assistance, Medicaid beneficiaries will have a choice of one MCO or FFS in all 55 counties in West Virginia.

Children eligible through the SED waiver will be mandatorily enrolled in the specialized MCO with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS.

___ 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) – choice of one MCO plan or Medicaid FFS

Enrollment for children in foster care and adoption assistance will default to the specialized MCO. The State will send 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. BCF Child Protective Services (CPS) workers will receive training on the managed care enrollment and disenrollment processes. Families with children in adoption assistance or BCF 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.

Families with children in adoption assistance who are also 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 with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS.

Rural Exception.

_X_ 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)):

For children eligible through the SED waiver residing in rural areas of the state, WV seeks an exception as the 1115 expenditure authority for this population will only cover urban areas.

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 and adoption assistance.

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)

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

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

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

Note: Children eligible through the SED waiver will be mandatorily enrolled in the specialized MCO with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS.

E. Populations Included in Waiver

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

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

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

__X__ Mandatory enrollment
____ Voluntary enrollment

Children qualifying for the State's SED waiver will be mandatorily enrolled with this 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 in foster care and in adoption assistance will be enrolled into managed care starting February 1, 2020. Children will default to the specialized MCO, but families of children in adoption assistance or CPS workers of children in foster care will have the option to disenroll the child from the MCO and utilize the FFS delivery system instead.

__ **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.

__X__ **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 pending 1915(c) SED Waiver called Children with Serious Emotional Disturbance 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 will be enrolled in the MCO effective the first 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 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 in foster care and adoption assistance.

   _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 SED waiver who will be mandatorily enrolled in the specialized MCO with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS. Per West Virginia's contract with the MCO, the MCO must allow the member 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:

In MCOs

- Following implementation of a state-defined Transition of Care Policy when the member is required to transition to a new MCO due to an external circumstance.
- 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): 30 minutes, 30 miles, or community standard

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

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe)

7.__ Pharmacies (please describe):30minutes or community standard

8.__ Pharmacies (please describe):30 minutes or community standard

9.__ Substance Abuse Treatment Providers (please describe):

10.__ 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): provide or refer for evaluation within 24 hours

8.__ Other providers (please describe):

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

1.__ PCPs (please describe):

2.__ Specialists (please describe):

3.__ Ancillary providers (please describe):

4.__ Dental (please describe):

5.__ Mental Health (please describe):

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

7.__ Other providers (please describe):

d.__ Other Access Standards (please describe)

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

B. Capacity Standards

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

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

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

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

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

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

   a.___ 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 numbers 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 to 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.

   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.

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

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting

program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

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

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

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

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

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**. The following items are required.

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

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

The State has two mechanisms to identify persons with special health care needs in MCOs

1). All children 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 in adoption assistance, the

MCO is required to ensure that an initial assessment of each enrollee's health care needs is completed within ninety (90) calendar days of the effective date of enrollment. Assessments are completed by clinical nursing staff.

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 will be shared with the MCO as part of its enrollment roster.

3) The Department will also encourage 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://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Health_Form.pdf

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 children in adoption assistance, the MCO is required to ensure that an initial assessment of each enrollee's health care needs is completed within ninety (90) calendar days of the effective date of enrollment.

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

1. X Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2. X Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. X In accord with any applicable State quality assurance and utilization review standards.

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

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

   a.___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 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.

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, 438.242, and 42 CFR Part 438 Subpart E in so far as these regulations are applicable.

The state has developed a quality strategy called, "Specialized Managed Care Plan for Children and Youth Program State Strategy for Assessing and Improving Managed Care Quality". The current version will be posted on the BMS website once the MCO procurement process is finalized and submitted to CMS.

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

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

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

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

The State will contract with an EQRO to perform the mandatory EQR activities and some of the optional activities as noted. The data obtained from the mandatory and optional EQR-related activities will be used 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 To Be Conducted for Populations Covered under this Managed Care Waiver		
		EQR study	Mandatory Activities	Optional Activities
MCO	External Quality Review Organization (EQRO) to be procured in summer/fall 2019			
		Validation of Performance Improvement Projects (PIP) (*for preceding 12 months*)	X	
		Performance Measures Validation (PMV) (*for preceding 12 months*)	X	

		Compliance Review (*for previous 3-year period*)	X	
		Network Adequacy Validation (*for preceding 12 months*)	X	
		Encounter Data Validation (EDV)		X *The state will contract with the EQRO for this task*
		Administration or Validation of Consumer or Provider Surveys of Quality of Care		X
		Calculation and Validation of Other Additional Performance Measures		X
		Conduct and Validate Other Additional PIPs		X
		Conduct Focused Quality Studies		X
		Assist with MCO Quality Rating and Develop Quality Rating System		X
		Provide technical guidance to the MCO to assist in conducting EQR activities that provide information for the EQR and the Annual Technical Report (ATR)		X
PIHP	N/A			

The state will also contract with the EQRO to:

- Perform a Quarterly Analysis of Reports of Pre-service Denials, Appeals, and Grievances from the MCO

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): Reduce or withhold management fees.

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

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

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

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

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

a.__ Initial credentialing

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

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

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

   The West Virginia Department of Administration (DOA), Purchasing Division will issue a solicitation as a Request for Proposal ("RFP"), as authorized by W. Va. Code §5A-3-10b, for DHHR to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance.

   Each MCO vendor must submit proposals in two distinct parts: technical and cost. Proposals will be evaluated in two parts by a committee of three (3) or more individuals. The first evaluation will be of the technical proposal and the second is an evaluation of the cost proposal. The MCO vendor that demonstrates that it meets all of the mandatory specifications required, attains the minimum acceptable score and attains the highest overall point score of all vendors shall be awarded the contract.

   Proposals will be evaluated based on criteria set forth in the solicitation and information contained in the proposals submitted in response to the solicitation. Proposals passing the Initial Review will be evaluated and scored across five (5) global criteria, with each receiving a percentage of the overall total (1,000) points, as seen in the Table below. The technical evaluation will be based upon the point allocations designated below, for a total of 700 of 1000 points. Cost represents 300 of 1000 total points.

Scoring Allocations

Scoring Area	Points Possible
Global Criterion 1: Vendor Qualifications and Experience	50
Global Criterion 2: Project Organization & Staffing	150
Global Criterion 3: Business Solution	480
Global Criterion 4: Oral Presentations	20
Global Criterion 5: Cost Proposal	300

Vendors must score a minimum of 70% (490 points) of the total technical points possible in order to move past the technical evaluation and have their cost proposal evaluated. All vendor proposals not attaining the Minimum Acceptable Score (MAS) will be disqualified.

The criteria used to select Managed Care Organization under the waiver include:

- Candidate must be a National Committee for Quality Assurance (NCQA) accredited entity and remain so for the duration of the contract or be in the process of becoming NCQA accredited. NCQA certification must be provided prior to contract start date.
- The vendor must have experience working with children and youth populations requiring specialized care.
- The vendor must demonstrate experience within the last three (3) years as the prime contractor for at least three (3) federal, state, or private healthcare entities, in an MCO and/or ASO capacity, where the proposed solution of similar size and scope is currently being or has been implemented.
- The Vendor must demonstrate at least five (5) years' experience in Medicaid and Health and Human Services.
- The approach proposed by the Vendor must have been previously implemented successfully in a State environment.
- The Vendor must have at least three (3) years' experience implementing the proposed approach with an organization similar size and scope to the State, in an MCO and/or ASO capacity, in compliance with all federal and state regulations.
- Must be able to demonstrate network adequacy standards for each covered population. These networks must be comprised of hospitals; primary care providers (PCPs); OB/GYNs; specialty care providers; dental providers; behavioral health providers and facilities; Substance Use Disorder (SUD) providers and facilities; and additional providers when it promotes the objectives of the Medicaid program as determined by CMS in sufficient numbers to make available all covered services in a timely manner.

    - In establishing and maintaining a network, MCOs must consider the following:
        - Anticipated member enrollment;
        - Expected utilization of services, taking into consideration the characteristics and health care needs of the specific populations covered by the MCO;

- Numbers and types of providers required to furnish all contracted services;
- Numbers of providers who are not accepting new Medicaid patients; and
- Geographic location of the providers and the enrollees considering distance, travel time, the means of transportation ordinarily used by these enrollees, and whether the location provides physical access for enrollees with disabilities.

- In order to meet access requirements, each MCO must meet specified provider-to-enrollee ratios and travel time and distance standards in every county. In the calculation for provider-to-enrollee ratios, MCOs may only count *unique providers* located within the county. For the time and distance standards, MCOs may count *all provider locations* within the county or within the appropriate travel time and distance from the county border. Travel time and distance standards are measured from the enrollee's residence to the provider's location. Network standards are consistent across the counties.

BMS will employ several oversight mechanisms to hold the MCO accountable for the quality of care provided to the enrollees, including contracting with an EQRO to perform external quality review (EQR) services. The EQRO will evaluate the quality, access, and timeliness of services provided as outlined in this waiver application (Part III: Quality, 1. Assurances for MCO or PIHP programs).

In addition, the selected MCO must complete a readiness review and an on-site readiness review before being awarded a contract.

The State is also creating a new Specialized Managed Care Unit within the BMS Managed Care Unit that will have staff dedicated specifically to this project. In addition, our Bureau for Children and Families (BCF) is hiring at least one staff person to help oversee the ASO services administered by the vendor. In addition to State staff, the Department will continue to leverage its contractors: The Lewin Group to assist with readiness review activities and provider network reviews; and BerryDunn for procurement assistance activities. The State is meeting regularly with its fiscal agent, DXC, on tasks that will be required of that vendor, such as file testing, call center support, capitation payment structure, etc. In November 2019, Aetna Better Health of West Virginia (ABHWV) was awarded the contract and has begun the readiness process. The State meets with them at least twice weekly to work on operational components of the transition to make sure the vendor is ready for February 1, 2020. All of these activities will occur in parallel with our continued coordination efforts with CMS/ACF.

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 plan 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 members;
- Member materials (Provider Directories, Member Handbooks, Member ID cards, etc.);
- Information to be used on the MCO's Website or the Internet;
- Print media; and
- Television and radio storyboards or scripts.

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 of nominal value to potential members. The MCO may not provide gifts to providers to distribute to potential members, unless such gifts are placed in the providers' office common areas and are available to all patients.

After enrollment, pertinent items (e.g., magnet with immunization schedule) MAY be approved by the State, but must be pre-approved. MCOs may only issue gift cards to members in connection with their participation in MCO initiatives in the areas of health education or improved medical outcomes (e.g., reward for participation in MCO prenatal program) unrelated to enrollment. The 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):

Currently no language other than English is spoken by more than 1% of the population. On an ongoing basis, the State reviews reports generated from the eligibility system, which records demographic information such as primary language at the time of the application, to determine prevalent languages. Within ninety (90) calendar days of notification from DHHR, the MCO will make written materials available in prevalent non-English languages in its service areas.

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 5%.

The State considers any language spoken by 5% or more of the program population to be significant.

iii.___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

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

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

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

2. Details.

a. Non-English Languages

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

The State does not require translation of enrollee materials into any other languages as English is the primary language spoken 99.9%). However, 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 __5_ percent or more of the potential enrollee/ enrollee population.

The State considers any language spoken by 5% or more of the program population to be significant.

3.___ Other (please explain):

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

The State requires the MCO to 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 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.

_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 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 notify an enrollee of the availability of the member handbook within five (5) business days of official enrollment notification to the MCO, in alignment with

the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval, issued January 20, 2017.

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 State also requires the MCO to develop and maintain a public website to provide general information about West Virginia's Specialized Managed Care Plan for Children and Youth managed care 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 DHHR office makes available to all potential enrollees information about the managed care programs and options through the Your Guide to Medicaid. It will be updated to incorporate this new specialized managed care program. The Your Guide to Medicaid can be accessed at https://dhhr.wv.gov/bms/BMSPUB/Documents/Guide%20to%20Medicaid%202018FinalApproved.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:

_X_ the State

The DHHR office makes available to all enrollees information about the managed care programs and options through the Your Guide to Medicaid. It will be updated to incorporate this new specialized managed care program. The Your Guide to Medicaid can be accessed at https://dhhr.wv.gov/bms/BMSPUB/Documents/Guide%20to%20Medicaid%202018FinalApproved.pdf

__ State contractor (please specify):

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 Specialized Managed Care Plan for Children and Youth managed care 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, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers in the enrollee's service area. The directory must also include the non-English languages spoken (including, but not limited to American Sign Language) by the providers or their interpreters; whether the provider has completed cultural competence training; identification of providers that are not accepting new patients; any provider group affiliations; provider specialties (as appropriate); whether the provider has office accommodations for people with physical disabilities (including offices, exam room(s), and equipment; and any restrictions on the enrollee's ability to select from network providers.

C. Enrollment and Disenrollment

1. Assurances.

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.

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 and adoption assistance, the Department will issue a notice to all eligible enrollees regarding their transition to managed care effective February 1, 2020. This will inform the member that their Medicaid benefits are not changing, just the delivery system through which they access them, as well as inform them of their choice to select the FFS alternative if they choose. The children will be auto-assigned to the MCO for February 1, 2020, however, the CPS worker or the adoptive parents may change the child back to FFS at any time between the original date of notification of the change to managed care (targeting November 1), or at any point after enrollment in the MCO. The notice will inform them that they have the right to opt out of managed care by contacting our BMS Member Services Division via our fiscal agent and requesting that the child be disenrolled from managed care and moved back to FFS. This change would be effective the 1st of the next month depending on the time of the month in which they call (e.g. after the managed care cut-off date in the month, it would not be effective until the 1st of the following month).

Pending CMS approval, the State plans to begin evaluating individuals for the SED waiver on or around October 1, 2019, with eligibility beginning February 1, 2020 under the specialized MCO. For children eligible through the SED waiver, as a condition of application, the member will be notified at the time the waiver slot is approved that the SED services will be delivered through the new specialized MCO and the child will be enrolled in that specialized MCO. Many of these individuals that will receive slots are already enrolled in managed care under the State's MHT program. They will simply transition from one MCO plan to the new specialized MCO plan.

On May 14, 2019, the US Department of Justice and the WV Department of Health and Human Resources entered into an agreement regarding services, programs and activities offered to children with serious mental conditions. The agreement is independent of this waiver, however, the implementation of the SED 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 here:
https://dhhr.wv.gov/News/Documents/2019.05.14%20DOJ%20Agreement.pdf

The Department current holds monthly child welfare stakeholder meetings that are open to the public in which the state shares information about the MCO model, as well as our other child welfare reform initiatives.

When there are changes related to the Specialized Managed Care Plan for Children and Youth program, local DHHR offices will be provided relevant updates and trainings. In-service trainings will be scheduled with local DHHR staff including BCF staff as needed to ensure they understand the new program.

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 quarter for the first year and then every six (6) months thereafter, 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 Specialized Managed Care Plan for Children and Youth 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.

X 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.):

Children in foster care and adoption assistance will be enrolled statewide into the new Specialized Managed Care Plan for Children and Youth beginning February 1, 2020.

The state plans to phase in individuals eligible for Medicaid as formerly in foster care (18-26); and children, youth, and parents at-risk of entering or re-entering foster care into the specialized plan at a later date (on or after July 1, 2020).

All eligible foster care enrollees and children in adoption assistance will be passively enrolled into the specialized MCO with the option to transition to fee-for-service.

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

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

__ Potential enrollees will have **__days**/month(s) to choose a plan.

__ 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

__ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

__ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

__ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: 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:

Foster care populations are enrolled automatically into the specialized MCO using day 1 auto-assignment logic, with an option to then opt out of managed care and placed

under FFS Medicaid. The SED waiver population must remain enrolled in the specialized MCO to retain eligibility for the 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 who lose eligibility for any length of time and then regain eligibility are auto-assigned to the Specialized Managed Care Plan for Children and Youth MCO. This process will follow the initial enrollment process and the family of the child in adoption assistance or the CPS worker of the child in foster care may choose to disenroll the child from managed care and obtain services through FFS.

For the SED waiver population, if a child loses eligibility for the waiver, they must reapply for waiver coverage through KEPRO. If the member remains Medicaid eligible, but ineligible for the waiver, they will transition back to Mountain Health Trust under a TANF category.

Both foster care and SED 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.

- ___ Enrollee submits request to State.
- ___ 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.
- ___ 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).

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

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

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

MCO Program

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

- Loss of eligibility for Medicaid or for participation in Medicaid managed care, including becoming a Medicare beneficiary
- Failure of the State to make a premium payment on behalf of a member (West Virginia insurance regulations require that MCOs be permitted to disenroll a member if the payer fails to make premium payments for that member)
- The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area
- Continuous placement in a nursing facility, State institution or intermediate care facility for intellectual/ developmental disabilities for more than 30 days
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO.
- Upon the beneficiary's death

The MCO may not terminate enrollment because of an adverse change in the enrollee's health status; the enrollee's utilization of medical services; diminished mental capacity; or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this or other enrollees). The MCO must assure BMS that terminations are consistent with the reasons permitted under the contract. The State has responsibility for promptly arranging for services for any recipient whose enrollment is terminated for reasons other than loss of Medicaid eligibility. The MCO submits a monthly report to BMS that identifies members 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 both the foster care and SED waiver 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. Assurances.

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

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

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

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

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

b. Timeframes

_X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

c. Special Needs

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

The state will have an Ombudsman for this program as is required per legislative mandate by HB2010. The Ombudsman will be independent of BMS and is an office currently under development within the DHHR 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 member 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. and will be monitored by State staff to review for trends and excessive denial rates that can then be addressed with the MCO to look at operational changes or education that may need to occur to ensure access to services that are required under both the 1915b and 1915c 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 are operated by:

___ the State
___ the State's contractor. Please identify:
___ the PCCM
___ the PAHP.

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

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

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

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

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

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

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

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

___ Other (please explain):

F. Program Integrity

1. Assurances.

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

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

The prohibited relationships are:

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

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

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be 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. The regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

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

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

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

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

Part I. Summary Chart of Monitoring Activities

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

Please note:

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

MCO and PCCM Programs

	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
Monitoring Activity	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												
Accreditation for Participation												✓
Consumer Self Report data	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Data Analysis (nonclaims)			✓	✓		✓	✓	✓		✓		✓
Enrollee Hotlines			✓									
Focused Studies												✓
Geographic mapping							✓	✓				
Independent Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan							✓	✓			✓	
Ombudsman	✓		✓		✓	✓					✓	
On-Site Review				✓	✓	✓	✓	✓	✓	✓		✓

	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
Monitoring Activity	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					✓		✓		✓	✓		✓
Performance Measures						✓	✓	✓	✓	✓		✓
Periodic Comparison of # of Providers								✓			✓	
Profile Utilization By Provider Caseload								✓				
Provider Self-Report Data												
Test 24/7 PCP Availability							✓					✓
Utilization Review				✓			✓		✓	✓		✓
Other: *Internal Review Process*		✓										

Part II. Details of Monitoring Activities

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

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

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

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

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

b._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 months from its operational start date in the Specialized Managed Care Plan for Children and Youth program. MCOs are required to keep current NCQA accreditation for their Medicaid lines of business and submit their accreditation status reports to BMS for review.

c._X_ Consumer Self-Report data

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

The MCO is required to annually conduct child (and adult as needed for the member population) member satisfaction surveys using the latest version of the Consumer Assessment of Health Plans Survey (CAHPS). The survey rates member'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 member'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, annually, on August 15, 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 first CAHPS survey for the Specialized Managed Care Plan for Children and Youth will not be initiated until the MCO has served members for a year.

d. X Data Analysis (non-claims)

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

Disenrollment Requests

The State reviews the reasons for disenrollment to determine if there are any underlying problems with access or quality of care. If trend analysis proves that there are issues pertaining to quality, access, or other related topics, a specific provider corrective action is requested of the provider.

Grievances and Appeals

All formal and informal grievances received by the MCO are categorized into one of four areas – service denied, payment complaint, service complaint, or quality of care. The MCOs also report the number of appeals. A summary of these grievances and appeals is provided to the State on a quarterly basis. The MCOs separately track and

report on grievances and appeals filed for medical, behavioral health and dental services or filed by or on behalf of children with special health care needs (CSHCN).

PCP Termination Rates and Reasons

MCOs are required to submit quarterly reports with a list of their PCP providers and panel sizes, and any additions or terminations. The MCO must provide BMS with advanced written notice of any PCP network deletions within 14 days.

Periodic MCO Reporting

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

Provider network

The MCO must provide an electronic provider directory monthly to the Department. Each quarter, the MCO must submit a provider network status report including a list of all PCPs with each PCP's panel size at the beginning and end of the quarter, the number of providers with open and closed panels, and the date of any PCP additions or terminations from the network. The MCO must provide BMS with notice of any PCP network changes or material changes of other providers affecting service delivery within 14 days. The MCO must report any changes in hospitals in the MCO's network to BMS immediately.

The MCO also submits information on network changes quarterly. The MCO submits 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 MCO's network.

Financial data

Annually, on or before June 1st, 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

MCOs 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 submits separate quarterly reports on member utilization patterns.

Encounter data

The MCO submits encounter data to the State on a monthly basis. Along with the encounter data submission, the MCO must submit:

- A detailed summary of the file submission to include total claims and dollars by service category;
- A detailed change log to include specifications for any change in the claims processing systems that has an impact of the representation of the data on the monthly encounter files. Examples of such changes include, but are not limited to, correction and adjustment processing, range and domain of extract variables, values of extract variables, and relationships between extract variables; and
- A dictionary containing definitions for all codes contained on the encounter record that are not defined in the public domain. Such variables include but are not limited to, provider specialty, type of service, place of service, and internal procedure codes.

The MCO must attest to the truthfulness, accuracy, and completeness of all encounter data each time data is submitted to BMS. Claims certificate is required from each provider submitting data to the MCO. The MCO must require its physicians who provide Medicaid services to have a unique identifier, which should be used in all encounter data submissions. The encounter data set will include at least those data elements as specified by BMS or necessary for CMS to provide data at the frequency and level of detail specified by the Secretary of the federal DHHS.

A contractor to the State standardizes all data for coding and adds each month's data to a historical master file that allows for program-wide analysis. The contractor develops annual encounter data summary reports addressing a variety of health service areas.

e. X Enrollee hotlines operated by State

The State's fiscal agent will provide enrollment support for the specialized MCO population. The State will monitor the activity of the enrollment hotline to ensure member needs are being addressed timely and professionally.

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).

g. X Geographic mapping of provider network

The State evaluates geographic mapping analyses of the existing MCO provider network on an annual basis to ensure that the network has adequate geographical coverage for all points within each county. Analysis of the MCO provider network, current at the time of geographic mapping, demonstrate whether the network provides geographic access within the established time and distance standards.

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

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

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

If applicable, the State will contract with an independent evaluator to provide this service.

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

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

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 will conduct 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 members. Any significant network changes, such as PCP termination affecting many members, must be reported to the State immediately, along with a description of how the members in the terminated PCP’s panel will be transitioned to different PCPs. The State will then conduct plan and county specific analyses to ensure provider network standards are still being met.

k. X Ombudsman

Per West Virginia HB2010, 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 members with filing grievances and addressing any other concerns.

l. X On-site review

The State’s EQRO will conduct 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. Compliance with service provision

requirements regarding family planning services, emergency care services, and FQHC-based services are also part of the review.

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, C, D, E, and F of the Final Rule), and guidelines from other quality assurance accrediting bodies such as NCQA. 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 members:

Subpart A: General Provisions – Information Requirements
- §438.10 Information Requirements

Subpart C: Enrollee Rights and Protections
- §438.100 Enrollee Rights

Subpart D: MCO, PIHP, and PAHP Standards
- §438.206 Availability of Services
- §438.207 Assurance of Adequate Capacity and Services
- §438.208 Coordination and Continuity of Care
- §438.210 Coverage and Authorization of Services
- §438.214 Provider Selection
- §438.224 Confidentiality§438.228 Grievance and Appeal Systems
- §438.230 Subcontractual Relationships and Delegation
- §438.236 Practice Guidelines
- §438.242 Health Information Systems

Subpart E: Quality Measurement and Improvement
- §438.330 Quality Assessment and Performance Improvement Program

Subpart F: Grievance and Appeal System
- §438.402 General Requirements
- §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
- §438.414 Information About the Grievance and Appeal System to Providers and Subcontractors
- §438.416 Recordkeeping Requirements
- §438.420 Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending
- §438.424 Effectuation of Reversed Appeal Resolutions

Program Integrity
- §438.608 Article III. Section 8.1.3 Program Integrity Contract Requirements

The EQRO will conduct the SPR in three phases: pre-site, on-site, and post-site. The pre-site phase includes a review of documentation submitted by the MCO such as internal policies, procedures, member handbooks, provider handbooks, newsletters, meeting minutes, access and availability monitoring reports, and other documentation that support compliance with the standards under review. The on-site phase is conducted 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.

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

X Clinical
X Non-clinical

The MCO 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, and
- Continuity and coordination of care.

Non-clinical focus areas include:

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

The MCO is required to maintain at least three performance improvement projects to achieve meaningful improvement in three focus areas. The State has the option to choose the focus areas. Project proposals must be approved by BMS and the EQRO

prior to project initiation. After improvement is achieved, it must be maintained for at least one year before the project can be discontinued.

The State's EQRO will conduct an annual review of each MCO's indicated PIP utilizing the CMS protocol, *Validating Performance Improvement Projects—A Project for Use in Conducting Medical External Quality Review Activities*. An annual report will be completed for the MCO and an aggregate report will be produced 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.

n. X Performance measures [**Required** for MCO/PIHP]

Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

To ensure ongoing quality of care in the program, the MCO is required to conduct and report a variety of performance measures, including from the Health Plan Employer 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.

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

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

q. X Provider Self-report data

X Survey of providers
___ Focus groups

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

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

t. X Other: (please describe)

The MCO must conduct at least twelve (12) focus groups throughout the year with youth, families and foster parents that have received services within a residential treatment facility. The focus groups should be used as an opportunity to provide the Department with feedback on where services are being most impactful, so programmatic changes may be made to improve the overall health of the program. The focus groups shall must target, at a minimum, the following six (6) areas:

1. Access
2. Service Delivery
3. Gaps in Support Systems
4. Engagement with System Staff
5. Cultural Competency
6. Consumer Knowledge of Services and Supports

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.

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

__ This is a renewal request.

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

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

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

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

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

Strategy:

Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

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

Strategy: Accreditation for Participation Confirmation it was conducted as described:

_ Yes
___ No. Please explain:

Summary of results:

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

Strategy: Consumer Self-Report Data 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: Data Analysis (non-claims) Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

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

Strategy: Enrollee Hotlines operated by State 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: Focused Studies

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: Geographic mapping of provider network 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: Network adequacy assurance submitted by plan 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: On-site review

Confirmation it was conducted as described:

__ Yes
__ No. Please explain:

External Quality Review Organization Activities

The Balanced Budget Act of 1997, which became effective in 2002, specified three mandatory EQR activities:

- 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; and

BMS will contract with an EQRO that will conduct all three mandatory activities annually.

Systems Performance Review (SPR)

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

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

Strategy: Performance Improvement Projects

Confirmation it was conducted as described:

__ Yes
__ No. Please explain:

Summary of results:

Performance Improvement Projects

The State requires the MCO to complete three performance improvement projects (PIPs). The State's EQRO, will validated the MCO's chosen PIPs as part of the annual external quality review. The validation will be completed 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.*

Performance Measure Validation

In an effort to uniformly measure MCO quality of care, BMS requires the MCO to report measures from nationally recognized measure sets such as CMS Adult and Child Quality Core Sets and Healthcare Effectiveness Data and Information Set (HEDIS®) measures.[2] The NCQA maintains and directs the HEDIS program.

The State's EQRO role is to validate the MCO performance measures, which is accomplished by:

- Evaluating the accuracy of the performance measures reported by (or on behalf of) an MCO
- Determining the extent to which the performance measures followed the specifications for the measures

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

Strategy: Utilization Review

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):

[2] The term *HEDIS* is a registered trademark of the NCQA.

Section D: Cost-Effectiveness

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

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

Appendix D1. Member Months

Appendix D2.S Services in the Actual Waiver Cost

Appendix D2.A Administration in the Actual Waiver Cost

Appendix D3. Actual Waiver Cost

Appendix D4. Adjustments in Projection

Appendix D5. Waiver Cost Projection

Appendix D6. RO Targets

Appendix D7. Summary Sheet

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

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Tony Atkins

c. Telephone Number: 304-356-4838

d. E-mail: Tony.E.Atkins@wv.gov

e. The State is choosing to report waiver expenditures base 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. X Population in the base year data
1. X 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. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _ Projected members month based on most recent quarter of data (2019Q2) continuing forward
_____

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

e. X [Required] List the year(s) being used by the State as a base year: __2019____. If multiple years are being used, please explain:

f. X [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _ SFY (July 2018 – June 2019)_____.

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

For Conversion or Renewal Waivers:

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

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. Formulas were updated accordingly in the Summary tab.

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/R1 to P2:

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

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

For Initial Waivers:

a. 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.

The following services were excluded from the analysis as they are not a part of this program or are covered under separate waivers: IHS inpatient and outpatient, skilled nursing home, ICF services, Tribal 638 services, HCBS services (for the non-SED population only), targeted case management, individualized alternative or enhanced services, and PCCM case management fees.

Furthermore, FFS services that will not be provided under the MCO contracts are also excluded from the cost effectiveness actual waiver costs in Appendix D3, as the MCOs will have limited ability to impact cost savings for these categories which are outside of the MCOs' purview.

Overall, line items on the CMS-64 that were excluded are: nursing facility, intermediate care services, prescribed drugs, pregnancy terminations, non-emergency medical transportation, home and community-based waiver services (for the non-SED population), and home health for enrollees with chronic conditions.

MCO covered services are defined within Appendix A of the Service Provider Agreement. In addition, the MCO will be responsible for coverage of the following services as outlined by the 1915c SED waiver:

Waiver Service	Description
Inpatient Hospital (includes psych)	Inpatient hospital services related to the treatment of mental disorders or substance abuse disorders.

IHS Inpatient	NA
Mental Health Facility	Services provided in an Institution for Mental Disease (IMD).
Psychiatric Residential Treatment Facility	Behavioral health rehabilitation performed in a children's residential treatment facility.
Skilled Nursing Home	NA
ICF-MR Private	NA
ICF-MR Public	NA
ICF-Other	NA
Physician Services (includes psych)	Services of a physician to an enrollee on an inpatient or outpatient basis.
Outpatient Hospital (includes psych)	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.
IHS Outpatient	NA
Prescribed Drugs (Unless physician-administered)	NA
Dental Services	Services provided by a dentist, orthodontist, or oral surgeon to the adult and pediatric population.
Other Practitioners (includes psych)	Other practitioner services covered by the State Medicaid Plan that are not covered by another category of service.
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.
Lab or Radiology (includes psych)	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.
Home Health Services	Nursing services, home health aide services, medical supplies suitable for use in the home.

Sterilizations	Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.
EPSDT Screening	Early and periodic screening, treatment, and diagnostic services to determine psychological or physical conditions in enrollees under age twenty-one (21). Based on a periodicity schedule. Includes services identified during an interperiodic and/or periodic screen if they are determined to be medically necessary.
Rural Health Clinic	Physician, physician assistant (PA), and NP providing primary care in a clinic setting.
FQHC	Physician, physician assistant (PA), and NP providing primary care in a clinic setting.
Tribal 638	NA
HCBS Waivers	Services provided in the individual's home or community to targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses and provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.
Education	Health education services rendered by providers to Medicaid members.
Other Care Services	NA
Early Intervention	NA
Diabetic Supplies	Disposable needle/syringe combinations and blood glucose test strips
Hemophilia Drugs, Spinraza, and Hep C drugs	NA
Non-emergency Transportation	NA
Abortion	NA
Family Planning	Services to aid enrollees of child bearing age to voluntarily control family size or to avoid or delay an initial pregnancy.

Targeted Case Mgmt - MR Waiver	NA
Individualized Alternative or Enhanced Services	NA
PCCM Case Management Fees	NA
Managed Care Capitated Services	Services covered by a managed care entity, reimbursed under a capitated model between the State Medicaid agency and the contract managed care entity.
Targeted Case Mgmt - MH/SA	Coordination of services to ensure that eligible Medicaid members with a mental health or substance use disorder diagnosis have access to a full array of needed services including the appropriate medical, educational, or other services.
Organ Transplant Services	NA
Case Management	Case Management services assist members in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is granted. The Case Manager is responsible for engaging the member and parent/caregiver in a partnership of shared decision-making and service plan development and implementation throughout their enrollment in the CSEDW. The Case Manager ensures and coordinates a comprehensive set of supports, resources, and strategies for the member and parent/caregiver. S/he works closely with providers to assure that waiver services and treatment modalities augment each other for optimal outcomes for members and families.
In-Home Family Therapy	In-Home Family Therapy consists of counseling and training services for the member and family provided by a licensed mental health professional. This service includes individual and family therapy in the family home and should assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to his/her mental illness and treatment, such as development and enhancement of the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.
Day Habilitation: Independent	Day Habilitation services facilitate the member's community inclusion and remaining in his/her home. Services include therapeutic recreation, job development, and independent living/skills building, and are provided in local

Living/Skills Building (Ages 15-21)	community settings (such as libraries, stores, parks, city pools, etc.). Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, and socialization, if these skills are affected by the waiver member's SED. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, employment skills, self-advocacy and informed choice necessary to successfully function in the home and community.
Prevocational Services: Job Development (Ages 15-21)	Job Development (CMS defined: Prevocational Services) provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Job Development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.
Respite Care (In and Out-of Home)	Respite care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. In-Home Respite must be provided in the member's home, which is defined as a natural family home or a certified therapeutic foster care home. Out-of-Home Respite must be provided by a certified therapeutic foster care home. Both types of respite may be provided in the local public community.
Supported Employment (Ages 18-21)	Supported Employment services are ongoing supports for members ages 18-21 who, because of their SED, need intensive support to obtain and maintain employment in an integrated, competitive work setting, compensated at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without SED. Services may include negotiation with prospective employers, job coaching, transportation, and other workplace supports that enable the member to be successful in integrating into the job setting.
Assistive Equipment	Assistive equipment refers to an item, piece of equipment or product system that is used to address the member's needs that arise as a result of his/her serious emotional disturbance (SED). The equipment should increase, maintain or improve functional capabilities of the member, assist him/her to avoid an out-of-

	home placement. This category can also include the evaluation of assistive equipment needs of a member, as well as costs of acquisition training.
Community Transition (Ages 18-21)	Community Transition services are non-recurring set-up expenses for individuals ages 18-21 who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household but do not cover room and board.
In-Home Family Support	In-Home Family Support services allow the member and family to practice and implement the coping strategies introduced by the in-home therapist. The family support worker works with the member and family on the practical application of skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; supporting, and encouraging new parenting techniques; helping parents learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents in applying specific and on-the-spot parenting methods in order to change family dynamics.
Mobile Response	Mobile Response services are 24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and his/her ability to function in the community as determined by the family. This service is intended to be of very short duration and primarily to link to other services and resources. This service may only be delivered in an individual, one-to-one session. This service includes: de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation.
Non-Medical Transportation	Service offered to enable waiver members to be transported to and from local, public community locations for services specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan.
Peer Parent Support	Peer Parent Support services are designed to offer support to the parent/guardian of the member with SED. The services are geared toward promoting parent/guardian empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/caregiver with a

	parent(s) who are raising or have raised a child with mental health issues and are personally familiar with the associated challenges.
Specialized Therapy	Specialized Therapy refers to activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of his/her SED. The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management.

For Conversion or Renewal Waivers:

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

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

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

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

For Initial Waivers:

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

   Savings estimated by comparing what the PMPM for services covered by MCOs would be under FFS vs. in the capitated rates.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Actuary, Independent Assessment, EQRO, Enrollment Broker: *$1.10 PMPM, or $364,892 for the waiver period (P1+P2)*	*$16.10 PMPM or $5,372,318 for the initial 17 months of the program*	*N/A*	

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 program.*

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
N/A	*N/A*	*N/A*	*N/A*
Total	*N/A*	*N/A*	*N/A*

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
N/A	*N/A*	*N/A*	*N/A*
Total	*N/A*	*N/A*	*N/A*

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:

Members will be defaulted into managed care and will have to actively opt out into FFS. Based on our experience in other states, the percentage of members expected to opt 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 stop/loss 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 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._X_ [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._X_ 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.

CBO 10-year PMPY budget projections for Medicaid (separated for the following categories: children). Children: 7.3%/6.1% (2019-2020/2020-2021).

https://www.cbo.gov/system/files?file=2019-05/51301-2019-05-medicaid.pdf

For budget neutrality purposes for section 1115 waivers, CMS notes that the President's Budget trends are an appropriate benchmark to assess whether the waiver is at least as effective at controlling costs as national guidelines. "Limiting per capita cost trends to no more than the President's Budget trends reflects CMS's effort to align its approach to budget neutrality with federal budgeting principles and assumptions." Similarly, while this is a 1915b waiver, we still believe it is appropriate to use the aged, blind and disabled, child, and adult per member per year trend rates per the CBO for FYs 2018-2021 as our selected benchmarks for projection purposes. We do not believe it is appropriate to solely use the State's historic trend experience in future years to assess cost effectiveness; this would mean that that State would be expected to continually beat its historic trend experience. This is not appropriate as year over year managed care savings should be expected to decline for maturing programs. We assume the CBO trends reflect anticipated national changes such as technology, practice patterns, and units of service.

Please note that we are using the following number of trend months in our projections (midpoint to midpoint):

- R1 to P1: 15.6 months
- P1 to P2: 8.5 months (due to P1 only being 5 months in length)

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. X **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. X Changes in legislation (please describe):

For each change, please report the following:

A. X The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment __$34.33. The majority of the additional program change cost is due to the addition of the SUD waiver whose costs were negligible in the base period and are expected to continue to ramp up. The behavioral health fee schedule, ambulance, and FQHC reimbursement additional costs are all due to fee schedule changes. The IMD increased cost is due to remove any costs associated with IMD stays over 15 days for members are 21 and older, as well as for the new coverage of IMD stays under 15 days. Please see the 'Program Changes' tab of in 'Specialized CE Questions.xlsx' for additional detail.

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. X **Administrative Cost Adjustment*:**

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

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

2. X An administrative adjustment was made.

i.___ 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. X Other (please describe):

B1 to P1: we are assuming a 2% annual administrative cost trend (or 2.6% for 15.6 months), plus an additional $1.09 PMPM in new administrative expenses related to the transition from FFS to MCO following based on the 1915(b) MHT waiver experience for the following categories:

- External review ($0.18 pmpm)
- Enrollment brokers ($0.59 pmpm)
- Other financial participation ($0.32 PMPM)

P1 to P2: we are assuming a 2% annual administrative cost trend (or 1.4% for 8.5 months).

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 State~~s can incl~~ude 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 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._X_ Other (please describe): N/A; pharmacy not included under MCO capitation arrangement

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:
i.__ Potential Selection bias was measured in the following manner:
ii.__ 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.

1.__ 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.

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

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

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: 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._X_ 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._X_ No adjustment was made.

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

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

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

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

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

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

1.___Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: 1.9% in aggregate for PY1 and 2.0% for PY2. Please document how that trend was calculated:

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

i.____State historical cost increases. Please indicate the years on which the rates are based:

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.__**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.__ An adjustment was necessary and is listed and described below:

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

For each change, please report the following:

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

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

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

D.___ ***Determine adjustment for Medicare Part D dual eligibles.***

E.___ Other (please describe):

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

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

iv.___ Changes brought about by legal action (please describe): For each change, please report the following:

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

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

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

D.___ Other (please describe):

v.__ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D.__ Other (please describe):

vi.__ Other (please describe):

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

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

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

D.___Other (please describe):

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

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

2.__ An administrative adjustment was made.

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

ii.__Cost increases were accounted for.

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

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

C.__State Historical State Administrative Inflation. The actual trend rate used is: <u>X% annually</u>. Please document how that trend was calculated:

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):

i. __ No adjustment was made.
ii. __ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   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**:

   B1 to P1: In addition to the 8.9% trend that is being applied for 15 months of trend per the President's budget (please see response to Q4 below), there will be an additional 6.9% in costs related to program changes (nearly entirely due to the new SUD waiver and the coverage of 15 stays under 15 days) and an additional $1.09 PMPM for new MCO-related administrative expenditures.

   P1 to P2: the annualized increase of 6.0% ties back to the President's budget trend of 6.1%.

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**:

   B1 to P1: In addition to the 8.9% trend that is being applied for 15.6 months of trend per the President's budgetthere will be an additional 6.9% in costs related

to program changes (nearly entirely due to the new SUD waiver and the coverage of 15 stays under 15 days) and an additional $1.09 PMPM for new MCO-related administrative expenditures.

P1 to P2: the annualized increase of 6.1% ties back to the President's budget trend of 6.1%. 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.