



Children and Adults Health Programs Group

April 30, 2014

Michael J. Willden
Director
Nevada Department of Health and Human Services
1100 East William Street, Suite 101
Carson City, NV 89710

Dear Mr. Willden:

The Centers for Medicare & Medicaid Services (CMS) is issuing an amendment to Attachment B of the Standard Terms & Conditions (STCs) for the Nevada section 1115 demonstration, entitled Nevada Comprehensive Care Waiver (NCCW) (Project Number 11W-00284/9), under the authority of section 1115(a) of the Social Security Act (the Act). This amendment is effective as of the date of the approval letter through June 30, 2018.

On April 9, 2014, the state requested that Attachment B be amended to reflect proposed modifications to the Care Management Organization (CMO) payment methodology. Specifically, the at-risk-fee and holdback calculation components were removed from the quality incentive payment methodology. The removal of the at-risk-fee and holdback calculation was necessitated due to a decrease in estimated enrollment figures that initiated the need for a change to the CMO vendor contract.

This approval is conditioned upon written acceptance from the state that it agrees with the amendments to Attachment B. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Ms. Elizabeth Matthews. She is available to answer any questions concerning your section 1115 demonstration. Ms. Matthews' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, and CHIP Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5433
Facsimile: (410) 786-8534
E-mail: Elizabeth.matthews@cms.hhs.gov

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Official communications regarding program matters should be sent simultaneously to Ms. Matthews and to Ms. Gloria Nagle, Associate Regional Administrator in our San Francisco Regional Office. Ms. Nagle's address is:

Centers for Medicare & Medicaid Services
San Francisco Regional Office
Division of Medicaid and Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid, and CHIP Services, at (410) 786-5647.

Sincerely,

/s/

Diane T. Gerrits
Director

Enclosures

cc: Eliot Fishman, CMCS
Gloria Nagle, Associate Regional Administrator, Region IX



Office of the Administrator

June 28, 2013

Michael J. Willden
Director
Nevada Department of Health and Human Services
1100 East William Street, Suite 101
Carson City, NV 89710

Dear Mr. Willden:

This letter is to inform you that Nevada's request for a new section 1115(a) Medicaid demonstration, entitled the "Nevada Comprehensive Care Waiver" (NCCW) (Project Number 11W-00284/9), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective from July 1, 2013 through June 30, 2018.

Under this statewide demonstration, Nevada will enroll individuals in care management programs who are eligible under the state Medicaid plan who have certain qualifying conditions and who are not eligible for the state's existing care management options (including the state's existing managed care organizations (MCOs)), except for American Indians/Alaska Natives (AI/ANs) whose participation is voluntary. The care management services will be provided by a care management organization (CMO), which is a primary care case management entity (PCCM). The state must ensure that all beneficiaries have a choice of care manager.

There are no other changes to benefits under this demonstration. All Medicaid benefits will continue to be provided on a fee-for-service (FFS) basis. Enrollment in the demonstration is mandatory for individuals with demonstration-qualifying conditions

As we have discussed, there are several requests from the state's April 24, 2012 proposal that we are not approving at this time. When Nevada has further developed its proposed Medical Home and Health Home Pilots we would be happy to work with you on an amendment to the demonstration to consider adding these components. The state's proposal also included a brief description of several items that might be included in Phase 2 of NCCW. CMS would need additional information (including data on the state's experience with Phase 1 of NCCW) before we could consider this aspect of the state's original proposal. Finally, we have not granted any waiver or expenditure authority relative to the enrollment processes for the state's MCO system.

Our approval of this demonstration is subject to the limitations specified in the enclosed approved expenditure and waiver authorities, and special terms and conditions (STCs). These documents specify the agreement between the Nevada Department of Health and Human Services and CMS. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived. All requirements of the

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Medicaid program as expressed in law, regulation, and policy statement not expressly identified as waived in the waiver authorities shall apply to NCCW.

This approval is also conditioned upon compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the state's obligations to CMS, including an evaluation of this demonstration, during the term of the approval period. This award letter is subject to our receipt of your written acceptance of the award, including the waiver authorities and the STCs, within 30 days of the date of this letter.

Your project officer is Ms. Elizabeth Matthews, who may be reached at (410) 786-5433 and through e-mail at Elizabeth.Matthews@cms.hhs.gov. Ms. Matthews is available to answer any questions concerning your section 1115 demonstration. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Matthews at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communication regarding program matters should be submitted simultaneously to Ms. Elizabeth Matthews and Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Centers for Medicare & Medicaid Services
San Francisco Regional Office
Division of Medicaid and Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

We appreciate your cooperation throughout the review process, and look forward to successful implementation of this demonstration. If you have additional questions, please contact Ms. Jennifer Ryan, Acting Director of the Children and Adults Health Programs Group within the Center for Medicaid & CHIP Services, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Marilyn Tavenner

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Enclosures

cc:

Ms. Cindy Mann, CMCS

Ms. Jennifer Ryan, CMCS

Ms. Gloria Nagle, ARA, San Francisco Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11W-00284/9

TITLE: Nevada Comprehensive Care Waiver (NCCW)

AWARDEE: Nevada Department of Health and Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning July 1, 2013 through June 30, 2018, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Nevada to implement the Nevada Comprehensive Care Waiver (NCCW) Medicaid section 1115 demonstration.

1. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to enable Nevada to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional care management services to certain high-cost, high need beneficiaries.

2. Comparability **Section 1902(a)(17)**

To the extent necessary to enable the state to provide additional care management benefits to the demonstration populations enrolled in a care management organization (CMO).

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable Nevada to restrict freedom of choice of provider through the use of mandatory enrollment in a care management organization (CMO) for the receipt of care management services. Beneficiaries must have a choice between at least two care managers within the CMO. No waiver of freedom of choice is authorized for any other type of provider, including family planning providers.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11W-00284/9

TITLE: Nevada Comprehensive Care Waiver (NCCW)

AWARDEE: Nevada Department of Health and Human Services

I. PREFACE

The following are the special terms and conditions (STCs) for Nevada's Nevada Comprehensive Care Waiver (NCCW) section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Nevada Department of Health and Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). CMS has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act) which are separately enumerated. These STCs set forth conditions and limitations on those waiver authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STCs neither grant additional waiver or expenditure authority, nor expand upon those granted separately. The STCs are effective as of July 1, 2013 unless otherwise specified. This demonstration is approved through June 30, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Delivery System – Care Management Organization
- VI. Enrollment
- VII. General Financial Requirements
- VIII. Monitoring Budget Neutrality
- IX. General Reporting Requirements
- X. Evaluation of the Demonstration
- XI. Schedule of State Deliverables
- Attachment A. Quarterly Report Content and Format
- Attachment B. CMO Quality Incentive Payment Methodology

II. PROGRAM DESCRIPTION AND OBJECTIVES

On April 24, 2012, the state of Nevada submitted a Medicaid section 1115 demonstration proposal, entitled the Nevada Comprehensive Care Waiver (NCCW). Nevada contracts with managed care organizations (MCOs) in urban Clark and Washoe counties; the remainder of the state operates Medicaid as a fee-for-service (FFS) program. Historically, this meant that many Medicaid beneficiaries did not have access to care management services which might be able to both improve quality of care and generate program savings. The NCCW will implement mandatory care management services throughout the state for a subset of high-cost, high-need beneficiaries not served by the existing MCOs. This subset of beneficiaries will receive care management services from a care management organization (CMO). This entity will support improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the CMO is mandatory for demonstration eligible individuals, except for the American Indian/Alaska Native (AI/AN) population.

This five year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll into the CMO to receive care management benefits; and
- Generate cost efficiencies for the state to support the long-term sustainability of the Medicaid program.

The NCCW demonstration will assist the state in its goals to:

- Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis;
- Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes); and
- Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost efficient manner.

The state's demonstration evaluation will include an assessment of the following hypotheses:

1. Enrollment in a CMO improves the quality of care for Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.

2. Enrollment in a CMO improves health outcomes for Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.
3. Enrollment in a CMO reduces the total and per capita costs of providing Medicaid services to Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.
4. Medicaid beneficiaries enrolled in a CMO are more satisfied with the quality of their health care than beneficiaries in the FFS system without the additional care coordination provided by the CMO.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** If a population eligible through the Medicaid state plan or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX and/or title XXI state plan amendment, if necessary; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.**
- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.
 - b. Compliance with Transparency Requirements 42 CFR Section 431.412: Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 14, as well as include the following supporting documentation:
 - i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide

evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

- ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. Quality: The state must provide summaries of: relevant External Quality Review Organization (EQRO) and other relevant quality reports issued by the state or its contractors; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
- v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. Documentation of Public Notice (42 CFR section 431.408): The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment (SPA). Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.
- b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.
- e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the state public notice process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 34, associated with the

quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 35.

16. **Federal Financial Participation (FFP).** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

Under the NCCW demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. A subset of state plan beneficiaries with specific diagnoses is affected by the demonstration through the requirement to receive care management services; all other state plan benefits for these beneficiaries are delivered FFS.

17. Eligibility Groups Affected By the Demonstration. The following charts describe the mandatory and optional state plan populations affected by this demonstration. Income and resources standards in the tables in STC 17(a) and (b) are intended to reflect those in the approved state plan; eligibility authority for these state plan populations resides in the state plan. Should the state amend the state plan to make any changes to eligibility for the populations listed in STC 17(a) and (b), upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request corresponding technical corrections to the tables in STC 17(a) and (b). These corresponding technical corrections will not take effect until the approval of the state plan amendment. Subject to the limitations in STCs 18 and 19, individuals in the populations identified in the tables in STC 17(a) and (b) are only eligible for the demonstration to the extent that the individual has been diagnosed with a condition identified in STC 20 and has been enrolled by the state in a CMO.

- a. **Medicaid State Plan Mandatory Populations.** Please note that individuals in the table below are only eligible for the demonstration to the extent that the individual has been diagnosed with a condition listed in STC 20 and has been enrolled by the state in a CMO.

State Plan Mandatory Medicaid Eligibility Groups	Description	Income Standard	Resource Standard	Medicaid Eligibility Group (MEG)
LOW INCOME FAMILIES WITH CHILDREN	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A)(i)(I) • SSA 1931 • Eligibility rule CFR 435.110 	TANF payment standard	\$2,000 (single) \$3,000 (couple)	TANF (AFDC)
PREGNANT WOMEN AND CHILDREN	<ul style="list-style-type: none"> • CFR 435.116 and 435.118 • SSA 1902 <p>This program is mandatory qualified pregnant women, and mandatory poverty-level related pregnant women and children.</p>	133% for pregnant women and children <6 100% for children aged 6-18	N/A	TANF (AFDC)

<p>TRANSITIONAL RELATED MEDICAID-TRANSITIONAL MEDICAL ASSISTANCE (TMA)</p>	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A)(i)(I) • SSA 408(a)(11)(A) • SSA 1925 • SSA 1931(c)(2) <p>Coverage for up to 12 months is provided to families who receive coverage on the Low Income Families with Children program and have lost financial eligibility due to earnings, increase in working hours, or loss of time-limited earned income disregard. Income must exceed guidelines for Low Income Families with Children program.</p>	<p>Up to 185% of the FPL for the family's earned income minus child care expenses</p>	<p>N/A</p>	<p>TANF (AFDC)</p>
<p>EXTENDED POST MEDICAL</p>	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A)(i)(I) • SSA 408(a)(11)(B) • SSA 1931(c)(1) <p>Coverage for 4 months is provided to families who received coverage on the Low Income Families with Children program and lost financial eligibility due to an increase in child or spousal support. Income must exceed guidelines for Low Income Families with Children program.</p>	<p>N/A</p>	<p>N/A</p>	<p>TANF (AFDC)/CHAP</p>
<p>ADOPTION SUPPORT MEDICAL (IV-E)</p>	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A)(i)(I) • 473(b)(3) • IV-E Adoption Support Program, Public Law 96-272 <p>This program is for adopted children with special needs who were in state custody and meet the eligibility criteria for federal participation in the IV-E adoption support program.</p>	<p>Federal IV-E children are Medicaid eligible, with identified condition, regardless of FPL.</p>	<p>N/A</p>	<p>TANF (AFDC)/CHAP</p>

<p>SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS</p> <p>And Deemed SSI Recipients</p>	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A)(i)(II) SSI recipients. • SSA 1902(a)(10)(A)(i)(II)(aa) disabled children who lost SSI when the definition of disability for children changed in 1996. • SSA 1902(a)(10)(A)(i)(II)(cc) individuals who are under 21 years of aged eligible for Medicaid in the month that applied for SSI. • SSA 1619(a) • SSA 1905(q)/1902(a)(10)(A)(i)(II)(bb) • SSA 1619(b) <p>Qualified low-income elderly or disabled people whose household incomes fall below certain levels.</p>	<p>100% Federal Benefit Rate (FBR)</p> <p>Earned income is less than the threshold amount as defined by Social Security. Unearned income is the SSI amount.</p>	<p>\$2,000 (single)</p> <p>\$3,000 (couple)</p>	<p>MAABD</p>
<p>PICKLE AMENDMENT</p>	<ul style="list-style-type: none"> • Section 503 of Public Law 94-566 • 42 U.S.C., 1396a <p>Certain individuals who have lost SSI/SSP eligibility, but would still be eligible for SSI/SSP if some of their income were disregarded; may be Medicaid eligible if all other eligible requirements are met. Public law dictates what income is disregarded for each group.</p>	<p>100% Federal Benefit Rate (FBR).</p>	<p>\$2,000 (single)</p> <p>\$3,000 (couple)</p>	<p>MAABD</p>
<p>AGED & BLIND INDIVIDUALS-SSI SUPPLEMENT-INDEPENDENT LIVING(IL)</p>	<ul style="list-style-type: none"> • 42 CFR 435.130 • Section 402-Public Law 98-21 <p>This program is for states that are required to maintain the state supplemental payments in effect as of March 1st, 1983.</p>	<p>100% Federal Benefit Rate (FBR)</p>	<p>\$2,000 (single)</p> <p>\$3,000 (couple)</p>	<p>MAABD</p>

<p>DISABLED ADULT CHILDREN</p>	<ul style="list-style-type: none"> • 1634(c) • PL99-643 <p>Public Law 99-643 continues Medicaid eligibility for certain blind/disabled individuals ages 18 years or older if all other eligibility factors are met.</p>	<p>100% Federal Benefit Rate (FBR)</p>	<p>\$2,000 (single) \$3,000 (couple)</p>	<p>MAABD</p>
<p>EARLY WIDOWS AND WIDOWERS (Ages 60-64)</p>	<ul style="list-style-type: none"> • SSA 1634(d) • 42 CFR 435.138 <p>Disabled widows and widowers at least age 60 not entitled to Medicare Part A. Lost SSI or SSP because of mandatory application for receipt of early tile II disability benefits for widows and widowers. Would be eligible for SSI or SSP if title II benefit is deducted from income.</p>	<p>100% Federal Benefit Rate (FBR)</p>	<p>\$2,000 (single) \$3,000 (couple)</p>	<p>MAABD</p>
<p>DISABLED WIDOWS AND WIDOWERS</p>	<ul style="list-style-type: none"> • 1634(b) • 435.137 <p>Disabled widows and widowers who lost SSI/SSP because of an increase in title II disability benefits resulting from elimination of the additional reduction factor for disabled widows/widowers under age 60. Would be eligible for SSI or SSP if the Title II benefit was deducted from income. Closed group (the person had to apply for Medicaid on or before June 30, 1988).</p>	<p>100% Federal Benefit Rate (FBR)</p>	<p>\$2,000 (single) \$3,000 (couple)</p>	<p>MAABD</p>

b. **Medicaid State Plan Optional Populations.** Please note that individuals in the table below are only eligible for the demonstration to the extent that the individual has been diagnosed with a condition listed in STC 20 and has been enrolled by the state in a CMO.

State Plan Optional Medicaid Eligibility Groups	Description	Income Standard	Resource Standard	MEG
FOSTER CARE MEDICAL-AGED OUT. (AO) ¹	<ul style="list-style-type: none"> • SSA 1902(a)(10)(A) (ii)(XVII) • 42 U.S.C. 1397 • NRS 422.2717 <p>This program is for children transitioning to adult independent living who are no longer eligible under the Foster Care Medical program because they are turning 18 years old. Medicaid coverage may continue up to age 21. Medicaid coverage may continue up to age 26 as of 1/1/2014 based on implementation of ACA mandatory group for former foster care children.</p>	No income test	N/A	TANF (AFDC)/CHAP

¹ Effective January 1, 2014, this will become a mandatory population.

State Plan Optional Medicaid Eligibility Groups	Description	Income Standard	Resource Standard	MEG
TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIA)	<ul style="list-style-type: none"> SSA 1902(a)(10)(A)(ii)(XV) Ticket to Work and Work Incentives Improvement Act 1999 (TWWIA) <p>Working individuals with disabilities between 16 and 65. Income and resources equal to or below a standard specified by the state. (TWWIA Basic Group)</p>	The maximum gross unearned income standard is \$699. The maximum net income standard is 250% FPL	\$15,000 in non-excluded resources	MAABD
ADOPTION SUPPORT MEDICAL (NON IV-E)	<ul style="list-style-type: none"> SSA 1902(a)(10)(A)(ii)(VIII) 42 U.S.C. 671 <p>This program is for adopted children with special needs receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV-E adoption support program and met the Medicaid eligibility requirements at the time of adoption and are under age 19.</p>	Identified special need; criteria of IV-E foster care program; eligible for Medicaid, at the time of adoption.	N/A	TANF (AFDC)/ CHAP
AGED & BLIND INDIVIDUALS-SSI SUPPLEMENT-ADULT GROUP CARE FACILITY(AGCF)	<ul style="list-style-type: none"> 42 CFR 453.232 <p>This program is for states that provide an increase state supplement to residents of AGCFs-and in the home of another</p>	100% Federal Benefit Rate (FBR)	\$2,000 (single) \$3,000 (couple)	MAABD

18. **Exemption.** The following population is exempt from mandatory enrollment in a CMO and is not affected by this demonstration except to the extent that individuals elect to enroll in a CMO.

- a. American Indians/Alaska Natives (AI/AN): The AI/AN population will be allowed to voluntarily enroll in a CMO at the discretion of the individual beneficiary (subject to the individual having a demonstration-qualifying diagnosis as specified in STC 20). The individual may disenroll from the CMO at any time by notifying the state either verbally or in writing. The state will use the definition of Indian provided at 42 CFR 447.50.

19. **Eligibility Exclusions.** Notwithstanding STC 17, the following populations are excluded from this demonstration:

- All beneficiaries enrolled in a managed care organization (MCO);
- All beneficiaries dually eligible for Medicare;
- Individuals receiving case management services through the state's 1915(c) home and community based services (HCBS) waivers;
- Individuals enrolled in the state's Intellectual Disabilities/Developmental Disabilities (ID/DD or MR/DD) section 1915(c) waiver;
- Individuals in the state's title XXI Children's Health Insurance Program (CHIP) entitled Nevada Check Up;
- Individuals in the child welfare system (juvenile justice or foster care programs);
- Individuals receiving emergency Medicaid;
- Individuals receiving targeted case management; and
- Residents of Intermediate Care Facilities for individuals with Mental Retardation (ICF/MRs).

20. Demonstration-Qualifying Diagnoses. The NCCW demonstration eligibility is limited to individuals in the state plan populations identified in the tables in STC 17(a) and (b) with one of the following qualifying diagnoses, which renders the individual a beneficiary with high costs and high needs.

a. Demonstration-Qualifying Conditions:

- i. Asthma;
- ii. Cerebrovascular Disease, aneurysm, and epilepsy;
- iii. Chronic obstructive pulmonary disease (COPD), chronic bronchitis, and emphysema;
- iv. Diabetes mellitus;
- v. End stage renal disease (ESRD) and chronic kidney disease;
- vi. Heart disease and coronary artery disease (CAD);
- vii. HIV/AIDS;
- viii. Mental health; disorders including dementia, psychotic disorders, anxiety disorders, psychosis, paranoia, bipolar disorder, schizophrenia, amnesia, delirium and mood disorders.
- ix. Musculoskeletal system; diseases including osteoarthritis, spondylosis, disc displacement, Schmorl's Nodes, disc degeneration, disc disorder with and without myelopathy, postlaminectomy syndrome, cervical disorders, spinal stenosis, spondylolisthesis, nonallogenic spinal lesions, fracture of the femur and spinal sprain.
- x. Neoplasm/tumor;
- xi. Obesity;
- xii. Pregnancy;
- xiii. Substance use disorder; and
- xiv. Complex Condition/High Utilizer: Individuals with complex conditions incurring high treatment costs exceeding \$100,000 in claims.

b. Additional Qualifying Diagnoses. Any changes (removals and/or additions) to the demonstration-qualifying diagnoses specified in STC 20 are subject to the

amendment process specified in STC 7 and the public notice process specified in STC 14.

V. DELIVERY SYSTEM – CARE MANAGEMENT ORGANIZATION

21. **Care Management Organization.** The state will contract with a care management organization (CMO) which will provide direct care management for the demonstration population. A minimum of one CMO will operate throughout the demonstration approval period. The CMO shall be considered an enhanced primary care case management (PCCM) program, which shall operate within PCCM requirements as defined in 42 CFR 438. Should the CMO provide medical services consistent with 1905(a) of the Act, the CMO shall be considered a prepaid ambulatory health plan (PAHP) and operate under the regulations governing PAHPs in 42 CFR 438. The state must notify CMS in writing at least four weeks prior to any change from PCCM to PAHP.

- a. Responsibilities. The CMO is responsible for the components of care coordination, which are:
 - i. Comprehensive care management;
 - ii. Care coordination and health promotion;
 - iii. Coordinating transitional care, including coordinating appropriate follow-up, from inpatient to other settings;
 - iv. Coordinate access to individual and family support services;
 - v. Referral to community and social support services, if relevant; and
 - vi. Use of health information technology to coordinate services, as feasible and appropriate.
- b. Comprehensive Care Management Services. The CMO must provide the following care management services to all beneficiaries:
 - i. A comprehensive assessment (including physical, emotional, and psychological health, functional status, current health status, health history, self-management knowledge and behaviors, current treatment recommendations and medication, and need for support services) of each beneficiary to determine the individual's care and coordination needs;
 - ii. Assist beneficiaries in selecting a primary care provider (PCP); and
 - iii. Work with the beneficiary's Health Care Team to develop, manage, and maintain a care plan.
 1. The Health Care Team must, at a minimum, consist of: the beneficiary and/or the beneficiary's designee; the care manager; the PCP; licensed/certified behavioral/mental health specialists (based on

beneficiary need); a pharmacist (based on beneficiary need); a nutritionist (based on beneficiary need); and other key clinicians and caregivers as necessary based on beneficiary need.

- c. Additional Care Management Services. The CMO may provide the following care management services based on the needs of the beneficiary:
- i. *Disease management interventions*, which includes: one-on-one health coaching with licensed clinical professionals; facilitating behavioral changes; and may include online coaching tools;
 - ii. *Care management interventions*, which includes: identifying appropriate and necessary clinical interventions; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the PCP and other providers; and providing support to ensure access to evidence-based medical services for high risk beneficiaries with escalating care needs;
 - iii. *Oncology care coordination*, which includes: identifying appropriate and necessary clinical interventions; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the PCP and other providers; and providing support to ensure access to evidence-based medical services for beneficiaries with oncology treatment needs;
 - iv. *Chronic kidney disease management*, which includes: identifying appropriate and necessary clinical interventions; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the PCP and other providers; and providing support to ensure access to evidence-based medical services for beneficiaries with Chronic Kidney Disease (CKD);
 - v. *Mental health program*, which includes: an assessment and follow-up management for behavioral health issues; promoting communication between the PCP and health specialists; and support to ensure access to evidence-based medicine for beneficiaries with a serious and persistent mental health condition, acute mental health needs, or a mental health comorbidity associated with an acute and/or chronic condition;
 - vi. *Pregnancy care coordination* to reduce the incidence and severity of preterm births and very low birth weight births, and to facilitate coordination to maternal and child health programs. This includes: identifying appropriate clinical interventions that are needed; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the

PCP and other providers; and providing support to ensure access to evidence-based medical services for pregnant beneficiaries;

vii. *Complex condition care management* for individuals with complex conditions such as transplants, burns, and other high cost, high risk conditions. This includes: identifying appropriate and necessary clinical interventions; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the PCP and other providers; and providing support to ensure access to evidence-based medical services for high risk beneficiaries with escalating complex condition care needs; and

viii. *Health care management* for individuals who are high utilizers of medical services, including emergency rooms. This includes: identifying appropriate clinical interventions that are needed; performing an assessment and follow-up management for health issues; providing one-on-one coordination of those services; promoting communication between the PCP and other providers; and providing support to ensure access to evidence-based medical services for beneficiaries with escalating health care needs who are high utilizers of medical services.

d. Other Services. As a part of its obligation under STC 21(a), the CMO will also:

i. Provide enrollee education, including printed materials and online resources;

ii. Operate a nurse triage and advice call center;

iii. Provide support for continuity of care transitions (which occur when information about or accountability for an aspect of the beneficiary's care is transferred between health care entities);

iv. Operate an emergency department redirection management program (which supports beneficiaries in seeking care in the most appropriate setting); and

v. Link beneficiaries to community resources.

e. Payment. The CMO will be paid on a per member per month (PMPM) basis for all enrolled beneficiaries. This PMPM will serve as payment in full for services provided under the contract. The state may utilize withholds to ensure CMO contract compliance.

f. Quality Incentive Payments. In addition to the PMPM, the CMO may earn incentive payments for achieving certain quality improvement targets as specified in its contract with the state. Any revisions to the CMS-approved methodology must be submitted to CMS for review and approval. The state must not implement unapproved incentive payment methodologies. The approved quality incentive

payment methodology can be found in Attachment B.

- g. Qualifications. The CMO will employ a Medical Director, who will be a licensed physician. The Medical Director will provide clinical oversight to the nurse care managers, who will be registered nurses. The care managers will lead a health care team that includes licensed mental health specialists, pharmacists, nutritionists, Registered Nurses, and the Medical Director.
- h. Contracting. The CMS Regional Office must review and approve the CMO contract prior to implementation, and anytime a change in contract scope, or payment is made. The state must submit the contract and/or contract amendments for review and approval at least four week prior to the planned implementation date. The state must not implement unapproved CMO contracts or amendments.
- i. Access Requirements. The state must ensure that services are delivered in a culturally competent manner, and that the CMO has sufficient staff to allow enrolled beneficiaries a choice of care manager and to meet the responsibilities specified in STC 21 for all enrolled beneficiaries.
- j. Reporting. The state must provide an update on the CMO contracting (including contracted entity name, contract approval period, renewal/resolicitation, and compliance) in the quarterly and annual reports per STCs 55 and 56.

22. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

23. **Quality Strategy.** The state must adopt and implement a comprehensive and holistic, continuous quality improvement strategy that focuses on all aspects of quality improvement in the demonstration. The state may do this by either: (1) modifying its existing Quality strategy or (2) creating an additional, CMO-specific quality strategy. The Quality Strategy must include the quality measures tied to incentive payments under the CMO contract, which must in turn reflect the strategic goals of the demonstration. The state must revise its Quality Strategy whenever significant changes are made, including changes through this demonstration. The state must obtain the input of beneficiaries and other stakeholders in the development of its Quality Strategy and make the Strategy available for public comment. Pursuant to STC 56, the state must also provide CMS with annual reports on the implementation and effectiveness of its Quality Strategy as it impacts the demonstration.

- a. Within 30 days of approval, the state must notify CMS of its decision regarding whether to modify its existing Quality Strategy or to create an additional Quality Strategy to address CMO quality.
- b. The state must submit its draft Quality Strategy within 90 days of approval of the demonstration. CMS will review this strategy and provide comments to the state.

The state must then revise the Quality Strategy, taking into account and responding to CMS feedback, and submit a revised version within 45 days of receipt of CMS comments.

- c. The state must inform CMS in its annual report (STC 56) or in the bimonthly monitoring calls (STC 54) of any anticipated changes to the Quality Strategy. All revisions to the quality strategy must be submitted to CMS at least 60 days prior to implementation for review and comment. A final revised version, taking into consideration CMS feedback, must be submitted to CMS within 45 days of receipt of CMS feedback.

24. **NCCW State Advisory Committee.** The state must maintain for the duration of the demonstration, a public advisory group comprised of individuals, interested parties, and stakeholders impacted by the demonstration, regarding the impact and effective implementation of these changes. This advisory committee must meet at least twice per calendar year. Membership on this group should be periodically updated to ensure adequate representation of interested parties, stakeholders, CMO staff, and providers. The state must maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be included as an attachment to the annual report required in STC 56 and be made available to CMS upon request. The outcomes of the meetings may be discussed during the bimonthly demonstration monitoring calls in STC 54.

25. **Cost Sharing.** There is no cost-sharing related to the care management entities created through this demonstration. Any changes to this policy are subject to the amendment process specified in STC 7 and the public notice process specified in STC 14.

VI. ENROLLMENT

26. **Identification of NCCW Eligible Beneficiaries and Enrollment in the CMO.** Eligible beneficiaries will be identified based on the eligibility criteria in Section IV. Prior to enrolling any members in the CMO program, the state and the CMO must agree on the algorithm used to identify eligible beneficiaries. This algorithm must be consistent with these STCs and must be based on claims history and enrollment file data. Once the state and the CMO have reached an agreement on the algorithm, the CMO will submit an initial list of eligible beneficiaries to the state using the agreed upon algorithm at least 45 days prior to enrolling eligible beneficiaries. This list must be verified by the state's contracted actuary prior to enrolling eligible beneficiaries. Upon approval by the actuary, the CMO will begin enrolling eligible beneficiaries. The state will provide updated claims history and enrollment file data to the CMO on a monthly basis, at which time the CMO will apply the approved algorithm to the data to determine who is eligible for the program in that month.

- a. Notice to beneficiary. The state must provide notice of enrollment to the beneficiary in advance of any initial contact by the CMO.
- b. In accordance with the reporting requirements specified in STC 26(e) and (h), the state must ensure that enrollment in the CMO is not solely based on treatment costs.
- c. A request from the CMO or state to disenroll an individual must provide the specific reason for disenrollment.
- d. The state must require the CMO comply with the disenrollment protections specified in 42 CFR 438.56.
- e. For beneficiaries already enrolled in the CMO, the state must complete a demonstration eligibility re-assessment at least annually, or at more frequent interval as specified in the CMO contract. The state must require the CMO to report to the state the names of all individuals for whom a re-assessment is completed. The CMO must report to the state all individuals not referred for enrollment and the reason the individual was not referred. The CMO must also report all individuals disenrolled and the reason for disenrollment. The state must use this information to determine if individuals have been wrongfully determined ineligible.
- f. The state must audit a sample of these assessments at least annually, either directly or through the External Quality Review Organization (EQRO) or other appropriate state contracted vendor in order to verify the accuracy of the CMO's determinations.
- g. The state must notify CMS in writing of changes to the identification algorithm described in STC 26. This written notification must be submitted to CMS at least 90 days prior to the effective date of the change and must specify the reason for the change.
- h. Reporting.

- i. In each quarterly report required under STC 55, the state must report on the number of determinations that occur, by determination methodology (in person, telephonic, etc.), and the determination outcomes by determination methodology.
- ii. The state must report the number of disenrollments that occur, and the reason(s) for disenrollment, in each quarterly report required under STC 55.
- iii. The state must report on eligibility determination auditing in each annual report required under STC 56.

27. Beneficiary Rights and Protections. Individuals enrolled in the CMO will be afforded all rights under 1932(a)(4) and (5) of the Act, and any corresponding regulations that are not specifically waived. A beneficiary's compliance or participation in the NCCW demonstration and/or the CMO must not impact his or her Medicaid coverage. Further, a beneficiary must be afforded the right to participate in decisions regarding his or her health care, including the right to refuse treatment. The state must continue to provide state plan coverage/benefits and any other applicable Medicaid benefits regardless of a recipient being deemed noncompliant.

- a. The quarterly report required per STC 55 must include data regarding the number of recipients who have been categorized as noncompliant.

28. Beneficiary Choice - CMO. Beneficiaries must be allowed a choice between at least two care managers within the contracted CMO. Beneficiaries must be allowed to change care managers at any time.

29. Limited CMO Capacity. The state will operate this demonstration within an enrollment range of 37,000 to 41,500 beneficiaries, provided a sufficient number of individuals meet the eligibility requirements for the demonstration (see Section IV). The state must update CMS on changes in enrollment within this range during the monitoring calls required per STC 54, and in the quarterly and annual reports required per STCs 55 and 56.

- a. Enrollment Procedures. Upon initial implementation of the demonstration, the state will enroll individuals up to at least the minimum of 37,000 and no higher than the maximum of 41,5000 (the enrollment range).
 - i. Notwithstanding STC 26, once enrolled in the CMO an individual must be able to remain enrolled in the CMO provided he or she continues to meet the eligibility criteria under Section IV and maintains Medicaid eligibility.
 - ii. *Reserved Slots.* When operating enrollment above the minimum level, the state may reserve a state-determined number of slots in order to allow for the reenrollment of individuals who experience a gap in eligibility, provided total CMO enrollment does not decrease below the minimum enrollment

(see STC 29(b)). The state must report on the number of reserved slots in the annual report required per STC 56.

- b. Enrollment Minimum. The state must maintain a minimum enrollment of 37,000 individuals in the CMO (provided a sufficient number of individuals meet the eligibility requirements for the demonstration (see Section IV)).
 - i. If enrollment in the demonstration decreases below the enrollment minimum due to a lack of individuals who meet the eligibility criteria under Section IV, the state must immediately notify CMS in writing to describe the enrollment number and the reason(s) for the decrease in enrollment.
 - ii. All other adjustments to the minimum enrollment level are subject to the amendment process specified in STC 7.
- c. Enrollment Maximum. The state may increase enrollment to the maximum of 41,500 beneficiaries without advance notice to CMS (see STC 29 above). Requests to increase enrollment above this maximum are not subject to the amendment process specified in STC 7.
 - i. The state must notify CMS in writing at least 45 calendar days in advance of the proposed implementation date of requests to increase enrollment above the maximum specified in STC 29(c)(i). This request must include updated budget neutrality spreadsheets, projected enrollment estimates, and proposed enrollment targets.
- d. Waiting List. The state is authorized to maintain a waiting list any time it is not enrolling individuals into the CMO. Potential enrollees will be placed on the waiting list in chronological order of the determination of the individual's eligibility. As enrollment space becomes available either through attrition or an increase in enrollment, the state will re-examine the waiting list, beginning with the individual who has been on the list the longest and continuing in chronological order, to determine if the potential enrollee still meets the demonstration eligibility criteria. Following confirmation of demonstration eligibility, the state must notify the individual of his or her enrollment in the demonstration and the CMO.
 - i. *Notice to beneficiary*. The state must provide notice of enrollment to the beneficiary in advance of any initial contact by the CMO.
 - ii. *Waiting List Management Plan*. The state must submit its plan for managing the waiting list to CMS within 60 days of the approval of the demonstration.
 - iii. *Reporting*. The quarterly report required per STC 55 must include data regarding the number of demonstration-eligible beneficiaries on the waiting list, including how many have been added to the waiting list and how many

have moved from the waiting list to the demonstration for each month of the quarter. The state must also provide an overview of the status of the waiting list in the annual report required per STC 56.

VII. GENERAL FINANCIAL REQUIREMENTS

30. **Quarterly Expenditure Reports (CMS-64).** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of the STCs.
31. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX and section 1115 of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were made.
 - b. Reporting by Demonstration Year (DY) by Date of Service. In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in STC 83(g) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation payments must be reported in the DY that includes the month for which the payment was principally made. All other expenditures must be assigned to DYs according to date of service.
 - c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both

total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.

- e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
- f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.
- g. Demonstration Years. The first Demonstration Year (DY1) will be July 1, 2013 through June 30, 2014, and subsequent DYs will be defined as follows:

<u>Demonstration Year 1 (DY1)</u>	<u>July 1, 2013 to June 30, 2014</u>	<u>12 months</u>
<u>Demonstration Year 2 (DY2)</u>	<u>July 1, 2014 to June 30, 2015</u>	<u>12 months</u>
<u>Demonstration Year 3 (DY3)</u>	<u>July 1, 2015 to June 30, 2016</u>	<u>12 months</u>
<u>Demonstration Year 4 (DY4)</u>	<u>July 1, 2016 to June 30, 2017</u>	<u>12 months</u>
<u>Demonstration Year 5 (DY5)</u>	<u>July 1, 2017 to June 30, 2018</u>	<u>12 months</u>

- h. Use of Waiver Forms. For each quarter of each Demonstration Year, two (2) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the *Category Names* shown in quotation marks below, to report expenditures for the demonstration. Items i through ii below represent *Medicaid Eligibility Groups*(MEGs); STC 17 specifies the populations within each MEG. Expenditures should be allocated to these forms based on the guidance found below.
 - i. Temporary Assistance for Needy Families/Child Health Assurance Program [“TANF/CHAP”]
 - ii. Medical Assistance for the Aged, Blind, and Disabled [“MAABD”]

32. Expenditures Subject to the Budget Neutrality Limit. For purposes of this section, the term “expenditures subject to the budget neutrality limit” must include:

- a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan), but excluding the increase expenditures resulting from the mandated increase in payments to physicians per STC 80(f) made on behalf

of all demonstration participants listed in the tables in STC 17, with dates of services within the demonstration's approval period.

All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

33. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
34. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2 year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
35. **Reporting Member Months.** For the purpose of calculating the budget neutrality limit and for other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member months for the demonstration enrollees. Member-month enrollment information must be provided to CMS in conjunction with the quarterly reports pursuant to STC 55.
 - a. The state must report the actual number of member months for Eligibility Groups i and ii as defined in STC 31(h).
 - b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
 - c. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
36. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as

approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

37. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the following:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period.

38. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

39. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding

mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

40. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration (including but not limited to primary data on enrollment, quality, encounters, and expenditures), upon request, in a reasonable time frame.

41. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

VIII. MONITORING BUDGET NEUTRALITY

42. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method described in STC 45, and budget neutrality limits are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
43. **Risk.** The state shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality limit, but not for the number of demonstration eligibles. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have been realized had there been no demonstration.
44. **Expenditures Excluded From Budget Neutrality Limit.** Regular FFP will continue for costs not subject to budget neutrality limit. These exclusions include:
- a. Allowable administrative expenditures;
 - b. Mandated increase in physician payment rates in 2013 and 2014 (as specified in STC 31(f));
 - c. Disproportionate Share Hospital (DSH) payments;
 - d. Graduate Medical Education (GME) payments;
 - e. Pharmacy rebates (see STC 31(e)); and
 - f. Costs for excluded populations (see STC 19).
45. **Calculation of the Budget Neutrality Limit and How It Is Applied.** The following are the PMPM costs for the calculation of the budget neutrality limit for the demonstration enrollees in the MEGs listed in STC 31(h) under this approval period. *The demonstration year is July 1 through June 30.*
- a. The PMPM costs for the calculation of the annual budget neutrality limit for the eligibility groups subject to the budget neutrality limit under this demonstration are specified below.

Demonstration Eligibility Groups	Trend Rate	DY 1 (July 2013 – June 2014)	DY 2 (July 2014 – June 2015)	DY 3 (July 2015 – June 2016)	DY 4 (July 2016 – June 2017)	DY 5 (July 2017 – June 2018)
Temporary Assistance for Needy Families/Child Health Assurance Program	0.00%	\$109.32	\$109.32	\$109.32	\$109.32	\$109.32
Medicaid Aid for the Aged Blind & Disabled	0.00%	\$109.32	\$109.32	\$109.32	\$109.32	\$109.32

- b. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each MEG. An annual MEG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 35 for each MEG, times the appropriate per member per month (PMPM) costs from the table in STC (45)(a).
- c. The annual budget neutrality limit for the demonstration as a whole is the sum of the projected annual expenditure caps for each MEG calculated in subparagraph (b) above.
- d. The demonstration is structured as a “pass-through” or “hypothetical” population. Therefore, the state may not derive budget neutrality savings from the demonstration.

46. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 31(h) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

47. **Lifetime Demonstration Budget Neutrality Limit.** The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 45(c). The federal share of the overall budget neutrality limit (calculated as the product of the overall budget neutrality limit times the Composite Federal Share) represents the maximum amount of FFP that the state may receive for demonstration expenditures during the demonstration period reported in accordance with STC 31.

48. **Future Adjustments to the Budget Neutrality Limit.** CMS reserves the right to adjust the budget neutrality limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

49. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures

exceed the calculated cumulative budget neutrality limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit for DY 1 plus:	2.0 percent
DY 2	Cumulative budget neutrality limit for DY 1 + DY 2 plus:	1.5 percent
DY 3	Cumulative budget neutrality limit for DY 1 – DY 3 plus:	1.0 percent
DY 4	Cumulative budget neutrality limit for DY 1- DY 4 plus:	0.5 percent
DY 5	Cumulative budget neutrality limit for DY 1 – DY 5plus:	0 percent

50. Exceeding Budget Neutrality. If, at the end of this demonstration period, the cumulative budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

IX. GENERAL REPORTING REQUIREMENTS

51. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act as set forth in Section XIII of these STCs.
52. **Compliance with PCCM Reporting Requirements.** The state must comply with all PCCM reporting regulations at 42 CFR 438 et. seq.
53. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in Section VII of these STCs, including the submission of corrected budget neutrality data upon request.
54. **Bi-Monthly Monitoring Calls.** The state must participate in monitoring calls every other month with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, CMO operations (such as contract amendments, rate certifications, changes in provider qualification standards, provider relationships, on-going monitoring and oversight), state advisory committee meetings, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, progress on evaluations, state legislative developments, any changes to state plan eligibility, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
55. **Quarterly Reports:** The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but not be limited to:
 - a. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new CMOs; benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; pertinent legislative activity; and other operational issues;
 - b. Updates on the post award forums required under STC 15;
 - c. Action plans for addressing any policy and administrative issues identified;
 - d. Updates on CMO contracting per STC 21;
 - e. Quarterly enrollment reports that include the member months for each demonstration population and the end-of-quarter, point-in-time enrollment for each demonstration

population;

1. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
 2. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
- f. Data on demonstration eligibility determinations required under STC 26;
 - g. Data on disenrollment as required under STC 26;
 - h. Data on beneficiaries determined non-compliant required under STC 27;
 - i. Data on the demonstration waiting list, as required under STC 29;
 - j. Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY; and
 - k. Evaluation activities and interim findings.

56. Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state must submit the draft annual report no later than October 1 after the close of each demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

- a. All items included in the quarterly report pursuant to STC 55 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration populations for each DY, with administrative costs reported separately;
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, the total number of unique enrollees within the DY;
- d. Eligibility Determination Auditing. Pursuant to STC 26, the state must report on the results of its audit of the CMO’s eligibility determinations.
- e. Waiting List. Pursuant to STC 29, the state must provide an annual review of the state’s waiting list.

- f. Quality Strategy. Pursuant to STC 23, the state must report on the implementation and effectiveness of the updated Comprehensive Quality Strategy as it impacts the demonstration;
- g. State Advisory Committee. Pursuant to STC 24, the state must submit as an attachment to the annual report the meeting minutes from the NCCW State Advisory Committee meetings.
- h. Administrative Costs. The state must track and report additional administrative costs that are directly attributable to the demonstration. The state must specify how administrative costs for the demonstration compare to baseline administrative costs for the demonstration population.

57. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

X. EVALUATION OF THE DEMONSTRATION

58. Submission of Draft Evaluation Design. The state must submit a Draft Evaluation Design for an overall evaluation of the demonstration to CMS for review and approval within 120 days of CMS approval of the demonstration. At a minimum, the Draft Evaluation Design must include the specific research questions and hypotheses that are being tested, as outlined in Section II of the STCs and in STC 58(a).

Addressing the research questions identified in these STCs will require a mix of quantitative and qualitative research methodologies. It must also include: a description of the proposed baseline and comparison groups, as well as the methodologies for drawing population samples; qualitative and quantitative process, improvement, and outcome measures; and a discussion of data sources, including relevant enrollment systems, health information technology, claims processing systems, and encounter data systems. The state should describe which systems will be used as their sources of, and the frequency by which they will collect, the relevant data. The state must also provide a detailed analysis plan that describes the statistical methods that will be employed to isolate the effects of the demonstration from other initiatives occurring in the state. The Draft Evaluation Design must describe the state's process to contract with an independent evaluator.

In addition to any qualitative analysis, the evaluation must be based on a quasi-experimental design. Baseline and comparison groups must be established for both AFDC-related (TANF-related) and SSI-related beneficiaries. In addition, the AFDC-related and SSI-related populations must be further stratified by qualifying condition. Sampling and analytical methodologies must take into account the counties, delivery system, and period of enrollment. In its review of the Draft Evaluation Design, CMS reserves the right to request additional levels of analysis.

- a. Research Questions: The Draft Evaluation Design must, at a minimum, address the research questions/topics listed below in addition to the goals and hypotheses of the demonstration as outlined in Section II of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus of the evaluation, subject to CMS review and approval.
 - i. What is the impact of the CMO on: access to care; the quality, efficiency, and coordination of care; and the cost of care, for each demonstration population or relevant population group? The state must assess these impacts for each qualifying diagnosis.
 - ii. Did enrollment in a CMO yield any changes in total per capita costs (inclusive of care management costs) for high-need, high-cost beneficiaries? Did this vary by qualifying diagnosis? The state must include a comparison of pre- and post-demonstration per capita costs (total, medical, and administrative).
 - iii. How did outcomes, costs (total, administrative, medical), and quality

compare between the CMO and the state's FFS system for each demonstration-qualifying condition?

- iv. How did the CMO utilize health information technology?
- v. How has enrollment in the CMO improved follow-up after hospitalization for persons with asthma, coronary artery disease, COPD, heart failure, or mental health hospitalization?
- vi. How has enrollment in the CMO impacted utilization of primary care services?
- vii. Do members enrolled in the CMO program have fewer readmissions to hospitals as compared to historical fee-for-service data?
- viii. Does member enrollment in the CMO for pregnancies reduce the incidence and severity of preterm births and very low birth weight births as compared to historical FFS data?
- ix. Are individuals enrolled in the CMO satisfied with the care coordination provided?
- x. What impact does the use of reserved eligibility slots (per STC 29(a)) have on continuity of care?

59. Final Evaluation Design. CMS shall provide comments on the Draft Evaluation Design described in STC 58 within 60 days of receipt, and the state shall submit a Final Evaluation Design within 60 days of receipt of CMS comments. This Final Evaluation Design is subject to review; CMS reserves the right to request additional revisions prior to accepting the Final Evaluation Design.

60. Final Evaluation Design Implementation. The state must implement the Evaluation Design after submission of the Final Evaluation Design, and submit its progress in each of the quarterly and annual progress reports. The evaluation must be conducted by an independent evaluator.

61. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an Interim Evaluation Report as part of its request for each subsequent renewal.

62. Final Evaluation Report. The state must submit to CMS a draft of the Evaluation Report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the Final Evaluation Report within 90 days after receipt of CMS comments.

63. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
30 days from the date of award letter	Determine CMO Quality Strategy Location	Section V, STC 23
60 days from the date of the award letter	Draft waiting list management protocol	Section VI, STC 29
90 days from the date of award letter	Submit Draft Quality Strategy	Section V, STC 23
120 days from date of award letter	Submit Draft Evaluation Design	Section X, STC 58
Within 45 days of receipt of CMS comments	Submit Revised Quality Strategy	Section V, STC 23
Within 60 days of receipt of CMS comments	Submit a Final Evaluation Design	Section X, STC 59
Within 120 days of expiration	Submit a Draft Final Evaluation Report	Section X, STC 62
Within 120 days of expiration	Submit a Draft Final Report	Section VII, STC 57
90 days of receipt of CMS comments	Submit Final Evaluation Report	Section X, STC 62
Within 90 days of receipt of CMS comments	Submit Final Report	Section VII, STC 57

	Deliverable	STC Reference
Annual	By October 1 st - Draft Annual Report	Section VII, STC 56
	With Annual Report – NCCW State Advisory Committee Meeting Minutes	Section V, STC 24
Each Quarter (02/28, 05/31, 08/31, 11/30)	Quarterly Operational Reports	Section VII, STC 55
	Quarterly Enrollment Reports	Section VII, STC 55
	CMS-64 Reports	Section VIII, STC 30

ATTACHMENT A

Quarterly Report Content and Format

Under Section XII, STC 55, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Nevada Comprehensive Care Waiver (NCCW)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (7/1/2013 – 6/30/2014)

Federal Fiscal Quarter: 4/2013 (7/2013 - 9/2013)

Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval and operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months

Demonstration Populations	Enrollees at close of quarter (date)	Current Enrollees (to date)	Disenrolled in Current Quarter
<u>Population 1:</u> MAABD			
<u>Population 2:</u> TANF/CHAP			

Demonstration-Qualifying Conditions	Enrollees at close of quarter (date)	Current Enrollees (to date)	Disenrolled in Current Quarter
<u>Diagnosis 1:</u> Asthma			
<u>Diagnosis 2:</u> Cerebrovascular disease, aneurysm, and epilepsy			

ATTACHMENT A
Quarterly Report Content and Format

	Enrollees at close of quarter (date)	Current Enrollees (to date)	Disenrolled in Current Quarter
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema			
Diagnosis 4: Diabetes mellitus			
Diagnosis 5: End stage renal disease and chronic kidney disease			
Diagnosis 6: Heart disease and coronary artery disease			
Diagnosis 7: HIV/AIDS			
Diagnosis 8: Mental health			
Diagnosis 9: Musculoskeletal system			
Diagnosis 10: Neoplasm/cancer			
Diagnosis 11: Obesity			
Diagnosis 12: Substance use disorder			
Diagnosis 13: Pregnancy			
Diagnosis 14: Complex Condition/High Utilizer			

Outreach/Innovative Activities

Summarize marketing, outreach, or advocacy activities to current and potential enrollees and/or promising practices for the current quarter.

Operational Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues; approval and contracting with new care management organizations; care management benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; pertinent legislative activity; and other operational issues.

Care Management Contracting

Summarize the current status of CMO contracting (including effective dates and number of contracts). Discuss any changes to the CMO contract(s) the state expects to submit to CMS in the next two quarters.

Policy Developments/Issues

Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address any issues.

ATTACHMENT A
Quarterly Report Content and Format

Member Month Reporting

Enter the member months for each of the MEGs for the quarter, for use in budget neutrality calculations.

Demonstration Populations	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
<u>Population 1:</u> MAABD				
<u>Population 2:</u> TANF/CHAP				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Data regarding grievances, appeals, and state fair hearings, in summary and broken down by CMO and demonstration-qualifying condition, must be included.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter. The state must also report on the implementation and effectiveness of the Quality Strategy as it impacts the demonstration, and inform CMS of an anticipated change to the Quality Strategy. The state must report on the demonstration eligibility determinations each quarter, and on the number of beneficiaries who have been deemed non-compliant and “on demand for noncompliance.” The state must include the definition of non-compliant and “on demand for noncompliance” in each report.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
Care Management Organization (CMO) Quality Incentive Payment Methodology

The CMO will be paid \$15.35 on a per member per month (PMPM) basis for all enrolled beneficiaries. The PMPM will serve as payment in full for services provided under the contract. In addition to the PMPM, the CMO may earn incentive payments for achieving certain quality improvement targets as specified in its contract with the state. The attachment describes the approved quality incentive payment methodology as follows:

1. Reconciliation Methodology;
2. Operational and Reconciliation Data Requirements;
3. Data Extract and Reconciliation Timeframes;
4. Pay-for-Performance Methodology; and
5. CMO Quality Measures Chart

1. Reconciliation Methodology

The reconciliation methodology described in this document is approved for the first two demonstration years (DY), from July 1, 2013 – June 30, 2015. During this period the state shall work with CMS to refine or develop a new methodology for evaluating the effectiveness of the CMO and making incentive payments. The new reconciliation methodology must be completed and approved by CMS for implementation in DY s 3-5, July 1, 2015 – June 30, 2018.

The method for the annual financial reconciliation is based on the recommendation of the Care Continuum Alliance (CCA) in its Outcomes Guidelines (Volume 5). The goal of these guidelines is to balance suitability, rigor and precisions against acceptability, ease of use, and simplicity.

This method is an actuarially sound, population based pre-post study. The goal of this type of study is to provide symmetry between the baseline and program period - thus minimizing bias in the study.

A. Methodology Used to Calculate Program Net Reduction in Costs

Reconciliation Population

This population includes all Medicaid recipients meeting the eligibility and condition requirements to be eligible to receive care management services. This is the population where program net reduction in costs will occur.

Includes: The Medicaid eligibility categories of Aged, Blind and Disabled, Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) assistance groups. This population served by the CMO will encompass Medicaid recipients who have at least one chronic condition and/or a serious and persistent mental health condition as defined by the following criteria based on the CCA Guidelines as well as the CMO's own clinical standards:

ATTACHMENT B

Care Management Organization (CMO) Quality Incentive Payment Methodology

Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Heart Disease criteria are contained in the CCA Outcomes Guidelines Report Volume 5.

Additional condition inclusion criteria are as follows:

- i. End Stage Renal Disease: ICD-9-CM codes 585.6, V45.11, V56; ICD-9 Procedure codes 38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98; CPT-4 codes 36145, 36147, 36148, 36800, 36810, 36815, 36819, 36820-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90951, 90953, 90954, 90956, 90957, 90959, 90960, 90962-90970, 99512; HCPCS codes G0257, G0311, G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- ii. Cancer: ICD-9-CM codes 140-165, 170-176, 179-209, 230-239, 285.3; Diagnosis Rule: One face-to-face encounter/visit, in any setting, with any diagnosis of cancer (ICD9 diagnosis) in conjunction with any cancer treatment code, as identified in CPT/Rev/ICD-9 Procedures Code in Table RDI-A on page 23 of the 2011 Cost of Care Specifications PDF document.. The presence of both the ICD9 diagnosis and treatment code can occur at any time during the 1 year time period for identification.
- iii. Obesity: ICD-9-CM codes 278.0, V85.3, V85.4; Diagnosis Rule: 2 face to face visits in a 12 month period any position
- iv. Mental Health: ICD-9-CM codes 293.84, 295-298, 300.00-300.4, 307.1, 307.5, 308.0, 309.1-309.9, 311-314; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- v. Substance Abuse: ICD-9-CM codes 291, 292.0-292.2, 292.8-292.9, 303.0, 303.9, 304-305, 535.3, 571.1; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- vi. HIV/AIDS: ICD-9-CM codes 042, 079.53, 969, V08;
- vii. Chronic Kidney Disease: ICD-9 CM codes 585; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- viii. High Risk Maternity/Neonatal: ICD-9 CM codes 638, 640-642, 643.1-643.9, 644.0-644.1, 646-649, 651, 653.5-653.7, 654.5, 655-656, 657.0, 658.0, 658.1, 658.4, 658.8, 658.9, 659.4-659.7, V23, V91; Diagnosis Rule: Frequency of 1 face to face visits for any code in first or second position (primary or secondary diagnosis) within defined 9 month period
- ix. Care Transition IP Admissions: Person must have had an IP Admission with the following codes as primary or secondary diagnoses; ICD-9 CM codes 250, 295, 296, 298, 300.4, 309, 311, 345, 357.2, 362.01-362.07, 366.41, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 410-413, 415.12, 415.19, 416.2, 427-428, 430-432, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 438.13, 438.14, 440, 441.1-441.7, 441.9, 442, 443.1, 443.81, 443.89, 443.9, 444, 445.01, 445.02, 445.81, 445.89, 453.4, 453.5, 453.72-453.79, 466, 480-483, 484.1, 484.3, 484.5-484.8, 485-487, 490-492, 496, 514, 648.01-648.04, 671.4, 715, 721, 722.1-722.6, 722.73, 722.8-722.9, 723-724, 738.4, 739.1,

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Care Management Organization (CMO) Quality Incentive Payment Methodology

739.2, 739.4, 756.11, 756.12, 820, 846, 997.02; ICD-9 Procedure codes 36.01, 36.02, 36.05-36.07, 36.09, 36.1, 36.2; CPT-4 codes 32491, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536, 33572, 35600, 92980-92982, 92984, 92986, 92995, 92996; HCPCS codes G0302-G0305, S2205-S2209;

To determine visit types, the CMO uses HEDIS guidelines. When counting visits, only one visit per day is included.

Once an individual has been identified under the inclusion criteria above, that individual will remain eligible for the program, and therefore in the reconciliation population, for the duration of that individual's Medicaid eligibility. The two exceptions are:

- 1) The individual is identified under the pregnancy criteria, in which case eligibility will be limited to the earlier of a medical claim for delivery or nine months from initial qualification, and
- 2) The individual meets one or more of the criteria listed in "Excluded Population" below.

The Division of Health Care Financing and Policy (DHCFP) currently uses ICD-9 codes, but will begin using ICD-10 codes in October, 2015. The CMO must use the current version of the International Classification of Diseases (ICD) being used by the DHCFP. The State's contracted actuary and/or External Quality Review Organization (EQRO) will work with the CMO to transition and update the contract from ICD-9 to ICD-10 prior to October, 2015.

Trend Population

This population includes all Medicaid recipients meeting the eligibility but not the condition requirements to be eligible to receive care management services. This population should not experience program related net reduction in costs, and will be used to approximate population per-member-per-month annual cost trends. In the state's analysis of actual historical data, the difference between the annual cost trends of the reconciliation and trend populations must be no greater than plus or minus 2 percent. If the analysis produces cost trends that differ by more than 2 percent, then the state must propose and make adjustments to the assignment process (or other technical modifications that may be appropriate) to be reviewed and approved by CMS. Any adjustments to the assignment process made during the analysis to achieve an acceptable cost trend must be reflected in the description of the reconciliation and trend populations.

Excluded Population

All Medicaid recipients that either fail to meet the care management program eligibility requirements or meet one of the exclusion criteria (listed below) are to be excluded from both the Reconciliation and Trend Populations.

The following types of members are excluded:

- 1) Recipients who are dually eligible for Medicaid and Medicare coverage (i.e. dual

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- eligibles);
- 2) Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
 - 3) Recipients of Medicaid home and community-based services (HCBS) waiver case management services;
 - 4) Recipients of Medicaid covered targeted case management;
 - 5) TANF and CHAP recipients in services areas that require enrollment in a Medicaid Managed Care Organization (MCO);
 - 6) Those who reside in a full-time Skilled Nursing Facility;
 - 7) Recipients enrolled in the state's Intellectual Disabilities/Developmental Disabilities (ID/DD or (MR/DD) Section 1915 (c) Waiver;
 - 8) Recipients of the Title XXI Children's Health Insurance Program (CHIP) entitled Nevada Check Up;
 - 9) Recipients receiving emergency Medicaid; and
 - 10) Recipients residing in Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/ID).

Eligible Months

Eligible months are defined as members meeting the necessary Reconciliation or Trend Population eligibility and condition requirements, and not meeting any of the Excluded Population criteria as of the 15th day of the measurement month. If the requirements are met, the member's month is counted (one member month) and all of that member's claims incurred during the month are included. If the requirements are not met, the member's month is not counted (no member month) and all of the member's claims incurred during the month are excluded.

Calculation Steps

The process for calculating the program net reduction in costs for the care management population consists of the following steps:

- 1) Calculate an initial baseline Reconciliation Population Per Member Per Month (PMPM) cost using claims data net of exclusions.
- 2) Trend this baseline PMPM cost forward to the appropriate program period using the annual cost trend experienced by the Trend Population during this same period.
- 3) Calculate actual program period Reconciliation Population PMPM cost using claims data for each program year.
- 4) Calculate PMPM gross reduction in costs by subtracting the actual program period Reconciliation PMPM cost from the trended baseline Reconciliation Population PMPM cost.
- 5) Calculate total program period gross reduction in costs by multiplying the PMPM gross reduction in costs by the total program period Reconciliation Member Months.
- 6) Calculate total program period net reduction in costs by subtracting total program period care management fees from total program period gross reduction in costs.

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Steps 2 – 6 would be repeated for each program period.

In order to calculate PMPM cost, the population must be appropriately identified using identification and exclusion criteria that apply equally to both baseline and program periods. The identification and exclusion process is as follows:

Baseline Establishment

The baseline period includes the eligibility and incurred costs from the 12 months immediately prior to the beginning of program period 1 and will not be recalculated through the term of the contract (unless significant programmatic eligibility or identification criteria changes occur, which would need to be agreed upon by the State and the CMO before any recalculations would occur). Condition identification to determine members included in the Reconciliation Population uses claim diagnosis from claims incurred during the 36 months immediately prior to the beginning of program period 1. For cost calculations and condition identification, a 12 month claim payment lag (or run-out) is included in the final calculation to allow claim adjudication and payment to complete.

Identical client identification and eligibility methodologies are used for both the baseline and program periods to eliminate selection bias between periods. Claims (net of exclusions outlined below) for Reconciliation and Trend Population members are totaled in the baseline period to create the baseline PMPM costs for both populations.

The benchmark numbers to be used must be in the PCCM contract that is subject to review and approval by the CMS Regional Office.

Program Period Calculations

Program period calculations include the eligibility and incurred costs from the 12 months during each given program period (program periods consist of 12 months). Condition identification to determine members included in the Reconciliation Population uses claim diagnosis from claims incurred during the 12 months of the program period and 24 months immediately preceding the program period. For cost calculations and condition identification, a 12 month claim payment lag (or run-out) is included in the final calculation to allow claim adjudication and payment to complete.

Claims (net of exclusions outlined below) for Reconciliation and Trend Population members are totaled in the program period to create the program period PMPM costs for both populations.

Exclusions

All claims incurred during the baseline or program periods during months where the member does not meet the Reconciliation or Trend Population eligibility criteria.

Trauma claims during the baseline or program periods are excluded from claim

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cost/PMPM cost calculations as they are random in nature and therefore non-manageable. This does not imply that clients with trauma claims will be removed from the reduction in costs calculation, but rather **only the claims for traumatic injuries will be excluded**.

Trauma claims are defined as claims with one or more of the ICD-9 codes listed in the CMO contract Attachment AA.1, Table 4, "Master Code List: Trauma"

Outlier claim costs (excluding non-eligible and trauma claims) for an individual are capped at \$500,000 for any annual period (baseline or program periods). These claims tend to be random or one-time events, and add volatility to the measurement.

Exclusions apply equally to the Reconciliation and Trend Population and to the baseline or program periods.

Trend

The trend factors used are calculated as the measurement program period Trend Population PMPM cost divided by the baseline Trend Population PMPM cost. The Reconciliation Population PMPM cost is multiplied by the trend factor to calculate the expected program period Reconciliation PMPM cost, if no care management program were in place.

For example:

Trend Population baseline PMPM cost = \$100
Trend Population program period one PMPM cost = \$110
Trend factor for program period one = $\$110/100 = 1.10$
Reconciliation Population baseline PMPM cost = \$1,000

Reconciliation Population expected program period one PMPM cost
= $\$1,000 * 1.10 = \$1,100$

Risk Adjustment

A member month weighted risk score will be calculated separately for the Trend and Reconciliation populations for the baseline period and all program periods. Program period costs will be adjusted to account for changes in this risk score. This adjusted cost will be used in the determination of final reduction in costs.

The risk score will be calculated using the most recent available version of the Chronic Disability Payment System (CDPS) concurrent model.

For example:

Trend Population baseline risk score = 1.000
Trend Population program period one CDPS risk score = 1.100
Trend Population program period one PMPM cost = \$110
Trend Population period one adjusted PMPM cost = $\$110 \times (1.000 / 1.100) = \100

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In order to ensure that the calculated risk scores are consistent with expected costs as defined by this calculation, the following rules will be adhered to in the calculation:

- 1) Claims containing diagnosis codes found in Attachment AA.1 of the CMO Contract will be excluded from the risk score calculation.
- 2) Diagnosis codes associated with claim lines covering testing procedures will be excluded from the risk score calculation to ensure that the presence of testing procedures alone does not cause “false positives” for chronic conditions. Testing lines are defined in Tables 5 and 6 in Attachment AA.1 of the CMO Contract.
- 3) Children under age 21 are classified as “Child” for purposes of the CDPS risk adjustment methodology. All others are classified as “Adult.”
- 4) Aged/Blind/Disabled beneficiaries are classified as “Disabled” for purposes of the risk adjustment methodology. All others are classified as “AFDC/TANF.”

2. Operational and Reconciliation Data Requirements

The State of Nevada agrees to provide timely, accurate, and complete data for the CMO to be able to meet the net reduction in costs guarantee.

- A. Timely data is data that is delivered on the dates specified in the file transfer calendar that will be finalized by mutual agreement and included in the Data Management Manual.
- B. Accurate data is data that reflects the best-available information in the State of Nevada data systems and that is organized according to the data file layouts as documented in the Data Management Manual.
- C. Complete data is data that is in the format as specified in the Data Management Manual and includes values in all required fields for which Nevada has data, or contains all of the information from Nevada’s data warehouse, and contains the processed data that Nevada agrees to provide to the CMO as specified in the Data Management Manual.
- D. Unless otherwise mutually agreed upon, data provided on a monthly basis during the program period are the data-of-record for the program and the program guarantees. All performance measurement calculations will be based upon monthly eligibility and claims activity during ongoing program operations.
- E. The CMO is not required to independently verify the accuracy or completeness of data supplied by Nevada.

3. Data Extract and Reconciliation Timeframes

The reconciliation process will be conducted through claims and eligibility data extracts covering the time periods shown in Table 1 below. The compilation of these reconciliation data extracts allow for eligibility and claim adjustments to be compiled and for the State of Nevada and the CMO to have the same data starting points in completing reconciliations. The parties agree that all data received by the CMO from the State of Nevada in the reconciliation data extracts shall be the same data utilized to provide

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services and operate the Program during the performance periods.

These dates allow for three month interim reconciliations to be completed for quarterly program period performance evaluations. The dates in the table below may be adjusted to correspond with contract start date. However, this will not change the frequency of the performance evaluations.

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Table 1. Time Frames for State of Nevada Data Extracts

Deliverable File	Eligibility Period Begins	Eligibility Period Ends	Incurred Dates of Extracted Claims Used To Identify Target Population	Paid Date Cut-Off Of Claims Extract	Submittal Date to The CMO
Baseline	05/01/13	04/30/14	02/01/11-01/31/14	01/31/14	02/15/14
Program Period 1 – 3 Month	05/01/14	07/31/14	05/01/14-07/31/14	01/31/15	03/15/14
Program Period 1 – 6 Month	05/01/14	10/31/14	05/01/14-10/31/14	04/30/15	06/15/15
Program Period 1 – 9 Month	05/01/14	01/31/15	05/01/14-01/31/15	07/31/15	09/15/15
Program Period 1	05/01/14	04/30/15	05/01/14-04/30/15	10/31/15	12/15/15
Program Period 2 – 3 Month	05/01/15	07/31/15	05/01/15-07/31/15	01/31/16	03/15/16
Program Period 2 – 6 Month	05/01/15	10/31/15	05/01/15-10/31/15	04/30/16	06/15/16
Program Period 2 – 9 Month	05/01/15	01/31/16	05/01/15-01/31/16	07/31/16	09/15/16
Program Period 2	05/01/15	04/30/16	05/01/15-04/30/16	10/31/16	12/15/16

4. Pay-for-Performance Methodology

A. Description of Methodology

In addition to the fixed PMPM that will be paid to the selected Care Management Organization(s), an annual pay-for-performance payment will be made based on a net reduction in costs, if the CMO meets the criteria outlined in this section. It is a NCCW

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requirement that each year's reduction in costs must meet or exceed the prior year's reduction in costs to qualify for any portion of the pay-for-performance payment. The value of this payment will be calculated as follows:

$$\text{Bonus} = \text{Reduction in Costs} \times [50\% - (100\% - \text{Overall Quality Score})]$$

Note that, under this formula, the maximum bonus is equal to 50 percent of total cost reductions net of total program care management fees. The ratio of 50 percent is reduced by a function of quality unattained (100 percent less the quality score); and no bonus will be paid for a quality score of less than 50 percent.

The various components of the formula are built up as follows:

Reduction in Costs

The methodology and calculations to determine the achieved reduction in costs are defined in Sections 1 through 4 of this attachment.

Condition Specific Quality Scores (used to develop the Overall Quality Score)

The chart contained at the end of this attachment lists, by condition, the quality measures that will be used in the calculation of the condition scores.

The quality improvement target for each quality measure will be equal to 10 percent of the difference between 100 percent and the value of the measurement during the baseline period for the eligible population. In subsequent years, the quality measurement score must sustain or exceed the prior year's improvement in order to qualify for a pay-for-performance bonus. For example, if the value of a given quality measure during the baseline period was 60 percent, the Care Management Organization would be expected to increase the measure by 4 percent, to 64 percent. This is calculated as 4 percent = 10 percent x (100 percent – 60 percent). Each measure that shows improvement equal to or greater than the targeted improvement is considered “achieved.”

For each condition, the Condition Specific Quality Score would be calculated as the number of “achieved” targets divided by the total number of quality measures for that condition. As an example, if a particular condition has 4 quality measures, and the CMO achieved the required target for 3 of those measures, the condition score would be 0.75, or 75 percent. For single measures that require the reporting of multiple rates, that are not subsets of one another, all targets must be met in order for that condition's improvement to be considered “achieved.”

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Overall Quality Score

The value of “Overall Quality Score” included in the formula above will be calculated as a weighted average of Condition Specific Quality Scores (described below). The weights used for each Condition Specific Quality Score would be the proportion of individuals in the eligible population with that condition. The proportion would be calculated using member months, not unique individuals.

As an example, assume the following:

- Condition 1 score: 75 percent
- Condition 2 score: 100 percent
- Condition 3 score: 50 percent
- Prevalence of condition 1 in the eligible population (member months basis): 50 percent
- Prevalence of condition 2 in the eligible population (member months basis): 40 percent
- Prevalence of condition 3 in the eligible population (member months basis): 30 percent

Under this scenario, Overall Quality Score would equal:

$$\frac{75\% \times 50\% + 100\% \times 40\% + 50\% \times 30\%}{50\% + 40\% + 30\%} = 77.1\%$$

(Note that the total of all prevalence amounts is greater than 100 percent. This is to be expected, as many individuals in the eligible population will have more than one condition.)

B. Pay-for-Performance Bonus Expenditure Limit

The amount of pay-for-performance bonus the CMO is eligible to receive is subject to a cap of 50% of the total of all fixed care management fees paid to the CMO per demonstration year (DY).

Any changes to payment methodologies, is subject to CMS approval.

The quality measures to be used in the pay for performance calculation are listed at the end of this attachment.

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5. CMO Quality Measures Chart

Number	Short Name or Condition	Measure Steward	Performance Measure Definition
1	ASM.1 (Asthma)	HEDIS	Percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma who were appropriately prescribed medication during the measurement period
2	ASM.2 (Asthma)	AHRQ/ NQMC: 001614	Percent of patients who have a record of influenza immunization in the past 12 months
3	ASM.3 (Asthma)	NQF (1381) AL Medicaid Agency	Percentage of members enrolled during the measurement period with at least one emergency department visit or an urgent care visit for an asthma related event
4	ASM.4 (Asthma)	State- devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of asthma and had a follow-up ambulatory care visit within 7 days of discharge
5	SPR.1 (Chronic Obstructive Pulmonary Disease)	HEDIS	Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis
6	SPR.2 (Chronic Obstructive Pulmonary Disease)	NQMC: 002443	Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months
7	SPR.3 (Chronic Obstructive Pulmonary Disease)	State- devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge
8	CDC.1 (Diabetes)	HEDIS	Percentage of members 18 – 75 years of age, with diabetes, who had an HbA1c test performed in the measurement period
9	CDC.2 (Diabetes)	HEDIS	Percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) who had low-density lipoprotein cholesterol (LDL-C) test performed in the measurement period
10	CDC.3	HEDIS	Percentage of members 18 – 75 years of age, with

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	(Diabetes)		diabetes, who had a nephropathy screening test or evidence of nephropathy
11	CDC.4 (Diabetes)	HEDIS	Percentage of members 18 – 75 years of age, with diabetes, who had an eye screening for diabetic retinal disease in the measurement period
12	CDC.5 (Diabetes)	NQMC: 001605	Percentage of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period
13	CDC.6 (Diabetes)	HEDIS- LIKE	Percentage of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period
14	CAD.1 (Coronary Artery Disease)	State- devised, Actuary confirmed	Percentage of members identified with coronary artery disease (CAD) who were prescribed a lipid lowering medication during the measurement period
15	CAD.2 (Coronary Artery Disease)	State- devised, Actuary confirmed	Percentage of members identified with a coronary artery disease (CAD) who had an LDL-C screen performed during the measurement period
16	CAD.3 (Coronary Artery Disease))	State- devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge
17	HF.1 (Heart Failure)	NQMC: 007086	Percent of members 18 years and older who were hospitalized in the intake period with a diagnosis of acute myocardial infarction (AMI) and received persistent beta-blocker treatment for six months after being discharged alive
18	HF.2 (Heart Failure)	NQMC: 001399	Percent of members with heart failure who had at least one ED visit for acute exacerbation
19	HF.3 (Heart Failure)	HEDIS	Percent of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACEIs or ARBs during the measurement period and at least one serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement period
20	HF.4 (Heart Failure)	JAMA; Pub Med.gov published study	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge
21	HPTN.1 (Hypertension)	State- devised, Actuary confirmed	Percentage of members with hypertension who were on an antihypertension multi-drug therapy regimen, during the measurement period, that included a thiazide diuretic
22	HIV.1 (HIV/AIDS)	NQF-2079 Health Resources	Percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the

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		and Services Admin.- HIV/AIDS Bureau	measurement period, with a minimum of 60 days between each visit
23	MH.1 (Mental Health)	State-devised, Actuary confirmed	Percentage of members with bipolar I disorder treated with mood stabilizers at least 80% of the time during the measurement period
24	MH.2 (Mental Health)	NQF-0105 National Committee for Quality Assurance	Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days
25	MH.3 (Mental Health)	State-devised, Actuary confirmed	Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported: MH.3.1 – rate for 6 months of medication adherence MH.3.2 – rate for one year of medication adherence
26	MH.4 (Mental Health)	NQMC: 7104 NQMC: 7105	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:MH.4.1 – percentage of discharges for which the member received follow-up within 30 days of discharge (not used for P4P); MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge (used for P4P).
27	S.A.1 (Substance Abuse)	NQMC: 007135 NQMC: 007136	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported: S.A.1.1 – The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis S.A.1.2 – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.