Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

MMA Amendment Version
July 18, 2005

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

Facesheet

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

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

The **name of the waiver program** is *Integrated Care Network* . (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

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

__X_ amendment request for existing waiver, which modifies Section/Part _D___

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

X Document is replaced in full, with changes highlighted

____ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is ___replaced in full

___ carried over from previous waiver period. The State:

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

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___replaced in full

___ carried over from previous waiver period. The State:

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

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

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years; effective *October 1, 2018* and ending *September 30, 2023* (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is *Ginger Wettingfeld* and can be reached by telephone at *(334) 242-5018 or fax at (334) 242-5600, or e-mail at ginger.wettingfeld@medicaid.alabama.gov*. (Please list for each program)

Section A: Program Description

Part I: Program Overview

The current Alabama Long Term Services and Support (LTSS) system provides institutional care, and Home- and Community-Based Services (HCBS) to more than 23,000 elderly and disabled adults who meet the Medicaid financial eligibility requirements for long-term care and demonstrate need qualifying the individual for nursing facility level of care, as defined by the Alabama Medicaid Agency (Agency). More than 200 nursing facilities provide nursing facility care to more than 23,000 unduplicated Medicaid beneficiaries each year. There is an average of 16,000 individuals in a nursing facility on any given day across the State. HCBS are available statewide through HCBS waivers. As of 2016, there were 10,030 waiver slots across the two waiver programs intended for inclusion in the Integrated Care Network (ICN) program.

In light of anticipated increases in demand for LTSS, the Agency commissioned a Long Term Care Work Group to help prepare for these changes. The Long Term Care Work Group recommended the creation of the ICN program as a means to build LTSS system capacity to meet the anticipated future increase in demand, promote improved health care outcomes and reduce cost growth for this population.

With the implementation of the ICN program, the Agency intends to create a more sustainable infrastructure for the delivery of Medicaid-funded LTSS in Alabama. The Agency seeks to promote a person-centered approach to care delivery that includes improved management of beneficiaries' medical and LTSS needs, allowing them to receive LTSS in the least restrictive setting of their choice. The ICN will implement innovative approaches to:

- *Improve education and outreach about LTSS options*
- *Provide more comprehensive and integrative case management that drives person-centered planning, enhances quality of life, and improves health outcomes*
- *Help drive a shift in the percentage of the LTSS population residing in the HCBS setting*

The ICN will be a Primary Care Case Management (PCCM) entity. The Agency will contract with a single statewide ICN to serve ICN enrollees. The Agency will delegate the following activities to the ICN:

- *Case management*
- *Single point of entry supportive services*
- *Outreach and education activities*
- *Claims payment and processing for HCBS case management services*
- *Data management activities*

These activities are further described later in this application.

To enroll in the ICN program, individuals must be Medicaid eligible and must meet the nursing facility level of care. The nursing facility level of care is defined in Alabama Medicaid Administrative Code and includes a number of skilled nursing care services required by beneficiaries, in addition to any functional impairment of Activities of Daily Living (ADLs) such as transfer, mobility, eating, and toileting, or intermediate Activities of Daily Living (IADLs) such as medication administration.

Individuals who meet the Agency's financial eligibility criteria and who are determined by a physician to meet the defined level of care to qualify for a nursing facility will be required[1] to participate in the ICN program if they also fall into one of the following groups:

- ***Medicaid beneficiaries receiving care within a nursing facility**. Medicaid beneficiaries who currently receive custodial, long-term care within a nursing facility will be included in the ICN program.*
- ***Medicaid beneficiaries enrolled in select 1915(c) HCBS waiver programs**.*
    - *Elderly and Disabled Waiver Disabled (0068) – targeting individuals who are frail or physically disabled.*
    - *Alabama Community Transition (ACT) Waiver (0878) – targeting individuals currently residing in institutional long-term care who seek to transition to an HCBS setting.*

Individuals in the Poarch Band of Creek Indians who meet the eligibility criteria for the ICN program will be passively enrolled into the ICN, but will have the option to opt out of the program, as further described in IV.C.2.c.

The ICN program will serve the approximately 16,000 Medicaid recipients residing in nursing facilities long-term and up to 10,030 Medicaid recipients served through the Elderly and Disabled and ACT waivers, for a total of approximately 23,000 enrollees. The Elderly and Disabled and ACT 1915(c) waivers will run concurrently with this 1915(b) waiver application.

Activities Delegated to the ICN

Case Management

The ICN will be responsible for providing case management services for its enrollees. Case management services include:

- *Medical case management services for all enrollees who are identified by the ICN through a systematic approach as being in need of medical case management*
- *HCBS case management for individuals in the Elderly and Disabled and ACT waivers*

Medical Case Management

[1] *Individuals in the Poarch Band of Creek Indians will be passively enrolled into the ICN, but will have the option to opt out.*

The ICN will be responsible for identifying enrollees in need of medical case management, using a systematic approach approved by the Agency, and delivering medical case management services to those enrollees. Medical case management activities include:

- *Monitoring and confirming that enrollees receive recommended preventive care, including vaccinations and wellness visits*
- *Ensuring enrollees are linked to the appropriate providers*
- *Developing and assessing enrollees' medication lists*
- *Analyzing inpatient admissions and readmissions and emergency department utilization by enrollees and implementing strategies to mitigate preventable utilization*
- *Coordinating with HCBS case managers or nursing facility case management staff to integrate medical and long-term care needs, as applicable*
- *Coordinating with Medicare Advantage care coordinators for enrollees who are also members of Medicare Advantage plans*

The ICN is also required to develop coordinating agreements with nursing facilities, the Alabama Department of Mental Health, the Alabama Department of Human Resources, the Alabama Department of Public Health, and the Alabama Department of Senior Services (ADSS) to support coordination of services for enrollees.

HCBS Case Management

The ICN may contract with case management organizations (CMOs), which are typically the local Area Agencies on Aging (AAA), for HCBS case management services. The ICN and ADSS must use HCBS case management policies and procedures in accordance with the most recent version of the ADSS Long Term Care Policy and Procedure Guide. HCBS case management services include conducting and assessment, developing a care plan, and providing services coordination of HCBS. The ICN will have primary authority and responsibility over the CMOs and HCBS case management activities. ADSS will have primary authority and responsibility over Level of Care decisions and final approval of Person Centered Care Plans.

As approved in the State's Appendix K for 0068 and 0878 1915c waivers, there will be a temporary rate increase of 5.5% ($15) to the HCBS Case Management Rate. The rate increase is effective 6/1/2020 through the remainder of the Public Health Emergency. At the conclusion of the Public Health Emergency, the rate will return to the Pre-Public Health Emergency rate.

Single Point of Entry Supportive Services

The ICN will be required to coordinate with Alabama's Aging and Disability Resource Centers (ADRCs) and establish a single coordinating agreement applicable to all ADRCs. This agreement must be submitted to, and approved by, the Agency and ADSS, to assure that coordination standards do not impede the operation of the ADRC in serving non-Medicaid populations.

The ADRCs will refer Medicaid recipients in need of Medicaid LTSS (nursing facility or

HCBS waivers) to the ICN. The ICN is expected to support the operations of ADRCs by providing supplemental services for individuals referred to the ICN.

The Agency will delegate the following activities to the ICN; the ICN will offer these services, as applicable, to individuals referred to the ICN by ADRCs and nursing facilities:

- *Completing pre-admissions counseling and education for participants seeking Medicaid-funded LTSS services so that they can have knowledge sufficient to make informed choices about Medicaid-funded LTSS;*
- *Conducting a screening process that evaluates financial and level of care eligibility, choice of LTSS setting, needed 1915(c) services and access to unpaid, informal care;*
- *Facilitating the Medicaid application process for Medicaid applicants and the process to seek certification for LTSS;*
- *Educating individuals on documentation requirements and procedures; and,*
- *Referring individuals determined not to be Medicaid eligible back to their local ADRC for further assistance and/or navigation of the formal appeal process.*

The Agency will continue to maintain responsibility for determining Medicaid eligibility and determining whether an individual is eligible for the ICN program.

Outreach and Education

The ICN is also expected to conduct community education activities to promote public awareness of LTSS options and the general Medicaid eligibility requirements for qualifying for HCBS or institutional care. The ICN is expected to identify provider types that provide high-volumes of service to potential ICN enrollees. The ICN is expected to build professional relationships with these identified high-volume provider types and offer education to these provider types about LTSS options.

The ICN will be required to develop outreach and educational materials addressing the prevention of illness and disease, disease management and healthy lifestyles. The ICN will also be required to develop outreach and educational materials informing enrollees about the availability of transportation services and how to access non-emergency transportation services. The Agency will review and approve these materials prior to their use.

Claims Processing and Payment

The ICN will be responsible for the data required for claims processing and payment for HCBS case management services only. The ICN may choose to delegate this activity to the Agency's fiscal Agent, by entering into an agreement with the Agency's Fiscal Agent.

Data Management

The ICN will be required to use data summaries, dashboards, and extracts provided by the Agency to inform case management and provide outreach.

ICN Payment

The Agency will pay the ICN a per member, per month (PMPM) payment. The Agency will pay the ICN different PMPMs for HCBS enrollees and nursing facility enrollees.

For HCBS enrollees, a baseline PMPM will be calculated as current total HCBS case management expenditures divided by projected HCBS ICN enrollment. This starting point PMPM will be trended forward to the Fiscal Year (FY) 2019 and FY 2020 contract period. The baseline PMPM for nursing facility enrollees will be $0.

In addition to the current HCBS case management expenditures, anticipated new incremental medical case management and administrative costs will be added to the baseline PMPM for FY 2019 and FY 2020 for both nursing facility and HCBS enrollees.

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

Alabama has one federally recognized tribe, the Poarch Band of Creek Indians with members primarily located in one county.

The Agency sent a letter, and a hard copy of this document, by certified mail to the Tribal Chair of the Poarch Band of Creek Indians on September 10, 2021notifying the tribe of the amendments to the 1915b Waiver and requesting comments and concerns within 30 days of receipt of letter. To date the Agency has not received any comments or concerns. Additionally, the Agency provided expedited notice to the tribe electronically on September 22, 2021 for comments to be received within 10 days.

[Include Tribes response and concerns, if any, and Agency's response]

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

Not applicable; this is a new application.

A. Statutory Authority

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

a. __X_ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. _X **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

___ MCO
___ PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)
_X Other: please see section B.1.f. of this application for more detail.

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

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

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

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

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

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

B. Delivery Systems

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

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.___ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

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

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

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

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

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f. _X_ **Other:** *Please note that the ICN is a PCCM entity (PCCM-E). As the 1915(b) preprint does not currently provide an option for a PCCM-E, please note that throughout this preprint, when the application references a PCCM it is referencing a PCCM-E.*

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

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

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

1. **Assurances**.

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

The Agency will identify Medicaid recipients eligible for the ICN program and will automatically enroll them into the single ICN. ICN enrollment will be mandatory for all eligible Medicaid beneficiaries, with the exception of tribal members. The Agency will passively enroll tribal members into the ICN and provide them the opportunity to opt out of the ICN program. On a monthly basis, the Agency or its designee will send the ICN a file with the list of ICN enrollees.

The Agency will send new enrollees a letter notifying them of their enrollment in the ICN program. The letter to tribal members will also include information about their eligibility and the timeframe during which they can opt out of the ICN program. Once that timeframe has passed, the Agency will send a follow-up letter to tribal members notifying them that they will remain enrolled with the ICN. This letter will also include instructions for how to disenroll from the ICN.

In addition, the ICN must have a systematic approach to identify enrollees in need of medical case management and to deliver medical case management services to those enrollees. The Agency will review and approve the ICN's policies and procedures defining its medical case management activities, including the criteria for enrollees to qualify for medical case management services.

For each enrollee that the ICN identifies as in need of medical case management services, the ICN will mail the enrollee a letter with information about the medical case management program and the name and contact information for the enrollee's assigned Medical Case Manager. The ICN must assist enrollees to change their Medical Case Manager, upon request.

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

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

___ Two or more MCOs.

__ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X Other: (please describe): *ICN enrollees identified as in need of medical case management will have the option to change their assigned Medical Case Manager. ICN enrollees assigned to an HCBS waiver slot will have the option to change their assigned HCBS Case Manager. Because, nursing facility residents enrolled in the ICN do not access HCBS waiver services, nursing facility residents will not have an HCBS Case Manager; these individuals will have a Medical Case Manager through the ICN if they are identified as in need of medical case management.*

3. <u>Rural Exception</u>.

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

4. <u>1915(b)(4) Selective Contracting</u>

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

The State will contract with one ICN. The ICN will have a statewide service area.

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

D. Geographic Areas Served by the Waiver

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

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

___ **Less than Statewide**

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
All Counties: Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, Shelby, St Clair, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox, Winston	*PCCM Entity*	*Alabama Select Network*

E. Populations Included in Waiver

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

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

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

_X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment applies to individuals from the Section 1931 Children and Related Populations group who meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT Waiver*

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

_X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment applies to individuals from the Section 1931 Adults and Related Populations group who meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT Waiver*

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

_X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment applies to individuals from the Blind/Disabled Adults and Related Populations group who meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT Waiver*

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

_X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment applies to individuals from the Blind/Disabled Children and Related Populations group who meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT Waiver*

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

_X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment applies to individuals from the Aged and Related Populations group who meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT Waiver*

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

__*X*_ ***Other****:*

1. Long term nursing facility residents exceeding sixty (60) days of service in a year
2. Participants in the following HCBS Waivers:
- *Elderly and Disabled Waiver (0068)*
- *Alabama Community Transition (ACT) Waiver (0878)*

X___Mandatory enrollment
___ Voluntary enrollment

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

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

Note: Dual eligibles will be included in the ICN program if they also meet the nursing facility level of care and:

- *Are long term nursing facility residents exceeding sixty (60) days of service in a year; or*
- *Are receiving care through the Elderly and Disabled Waiver or ACT*

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

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

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

- *Individuals residing in a nursing facility will be included in the ICN program, but individuals living in an ICF/MR will be excluded from the ICN program*

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

- *Individuals enrolled in Alabama's PACE program will be excluded from the ICN program*

___ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

_X **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

- *Participants in the following 1915(c) waivers will be excluded from the ICN program:*
    - *Intellectual Disabilities Waiver (0001)*
    - *Living at Home Waiver (0391)*
    - *Technology Assisted (TA) Waiver (0407)*
    - *State of Alabama Independent Living (SAIL) Waiver (0241)*

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

- *Note: Members of the Poarch Band of Creek Indians will be included in the ICN program. The Agency will passively enroll members of the Poarch Band of Creek Indians into the ICN program and they will have the option to opt-out.*

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

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

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

_X **Other** (Please define):

The State is proposing to exclude the following additional populations:

- *Women eligible only for family planning services (via Alabama's 1115 Family Planning Waiver, "Plan First")*
- *Women eligible for the breast and cervical cancer program*
- *Individuals who do not require a nursing facility level of care*
- *Individuals receiving Medicaid funded hospice room and board in a nursing facility, or Medicaid funded hospice in the community*

F. Services

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

1. Assurances.

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

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

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

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

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

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

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

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

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

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

ICN enrollees can receive emergency services without prior authorization and without contacting the ICN.

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

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
__ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):
_X Family planning services are not included under the waiver.

Family planning services will continue to be paid for on a FFS basis, outside of the ICN program.

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

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

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

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

5. <u>EPSDT Requirements</u>.

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

6. **<u>1915(b)(3) Services</u>.**

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

7. **<u>Self-referrals</u>.**

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

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

1. <u>Assurances for MCO, PIHP, or PAHP programs</u>.

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

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

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

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

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

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):
2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Other providers (please describe):

d. _X__**Other Access Standards** (please describe):

The ICN may contract for HCBS case management services with existing network of CMO's. ICN enrollees will have access to all Medicaid fee-for-service providers for all other services.

In accordance with Alabama's approved 1915c waivers, 0068 and 0878, each CMO is responsible for maintaining and evaluating adequate staffing for the case management activities of the waiver programs. The excerpt below is from the waiver policy and procedure manual that defines what a minimum caseload should be dependent upon other factors specific to the CMO region as listed in the definition.

"Full-time HCBS Case Managers should maintain a caseload of 35-40 clients depending upon factors such as the geographic area to be covered and additional responsibilities and/or individual waiver program requirements."

Alabama Department of Senior Services, the 1915c Operating Agency, has a report that lists the number of clients billed per case manager per month by CMO. The ICN will review the approximate caseloads of the case managers and monitor the status of the case managers to best address the needs of the ICN population.

The HCBS Case Managers will travel to the enrollees' place of residence. The ICN will monitor HCBS case management activities including caseloads and enrollee contact, and report this information to the Agency on a monthly basis. The Agency and ICN will review the reports to monitor the caseload and frequency of enrollee contacts.

Medical case management services will be provided to enrollees who are systematically identified by the ICN as in need of medical case management services. The method of delivery, including home visits, frequency and caseloads for medical case management is determined by the ICN. The ICN must provide the Agency with a regular medical case management report that includes the number of enrollees assigned to each Medical Case Manager, number of contacts, and descriptive information about the medical case management services provided. The Agency will review the reports to monitor the caseload, frequency of enrollee contacts, and types of medical case management services provided.

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

B. Capacity Standards

1. <u>Assurances for MCO, PIHP, or PAHP programs</u>.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The ICN may contract for HCBS case management services with the existing network of CMOs providing these services. ICN enrollees will have access to all Medicaid fee-for-service providers for all other services.

Full-time HCBS Case Managers should maintain a caseload of 35-40 clients depending upon factors such as the geographic area to be covered and additional responsibilities.

The HCBS Case Managers will travel to the enrollees' place of residence. The ICN will monitor HCBS case management activities including caseloads and enrollee contact, and report this information to the Agency on a monthly basis. The Agency and ICN will review the reports to monitor the caseload and frequency of enrollee contacts.

Medical case management services will be provided to enrollees who are systematically identified by the ICN as in need of medical case management services. The method of delivery, including home visits, frequency and caseloads for medical case management is determined by the ICN. The ICN must provide the Agency with a regular medical case management report that includes the number of enrollees assigned to each Medical Case Manager, number of contacts, and descriptive information about the medical case management services provided. The Agency will review the reports to monitor the caseload, frequency of enrollee contacts, and types of medical case management services provided.

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

c. ___**Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

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

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

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

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

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

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

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

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

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

The ICN will develop outreach and educational materials addressing the prevention of illness and disease, disease management and healthy lifestyles. The Medical Case Managers will provide health education/promotion information on an as needed basis for enrollees who are identified as in need of medical case management services (e.g., have

certain chronic conditions, have frequent use of the emergency department).

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

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

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

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

The ICN will be responsible for identifying enrollees who could benefit from the development of medication lists to identify and resolve urgent and emergent drug duplications, interactions, possible adverse events, poor adherence or other suboptimal drug-taking behaviors. For these enrollees, the ICN will be responsible for developing and assessing enrollees' medication lists.

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

The Agency will delegate both medical case management and HCBS case management to the ICN.

The ICN will be required to coordinate medical case management activities with the HCBS case management activities, to promote a holistic approach to enrollees' care. The ICN will also have oversight of the HCBS case management process to ensure coordination between medical case management and HCBS case management. The ICN is required to use information technology systems and processes to integrate and share data elements for each enrollee including case management data.

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

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

The ICN must develop and submit to the Agency for approval its transition of care policies and procedures and a staffing model which must achieve a seamless, efficient transition with minimal impact to an enrollee's care. These policies must address transitions when individuals enroll with the ICN and disenroll from the ICN.

The transition of care policies must include how the ICN will maintain continuity of care for enrollees upon enrollment with the ICN, including maintaining necessary HCBS Case Management services. For enrollees receiving HCBS at the time of ICN program implementation, the ICN must preserve the same HCBS Case Manager assignment.

If an enrollee disenrolls from the ICN, the ICN must forward the enrollee's case management records to the entity assuming responsibility for the enrollee's case management needs.

Section A: Program Description

Part III: Quality

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

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 Subpart B, 438.204 438.340, 438.210, 438.214, 438.218, 438.10, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

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

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

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

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

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

2. <u>Assurances For PAHP program</u>.

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

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

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

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

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

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

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

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

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

4. _X Refer to program staff for further investigation;

5. _X Send warning letters to PCCMs;

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

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

8. ___ Change an enrollee's PCCM;

9. ___ Institute a restriction on the types of enrollees;

10. __X_ Further limit the number of assignments;

11. ___Ban new assignments;

12. ___Transfer some or all assignments to different PCCMs;

13. _X Suspend or terminate PCCM agreement;

14. _X Suspend or terminate as Medicaid providers; and

15. ___Other (explain):

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

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

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

   The Agency will post an RFP to solicit proposals for the ICN program. Based on the proposals received, the Agency will select one ICN. Please see section III.4 for more information on the process to select an ICN.

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

   The entity awarded the ICN contract will complete a readiness assessment, which will include a desk review and a site visit. The ICN will be required to provide documentation (e.g., policies and procedures, enrollee materials) for the desk review.

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

   A. ___ Initial credentialing

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

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

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

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

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

7. __ Other (please describe).

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

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

After reviewing the potential ICN proposals to determine that all required information is provided, an Evaluation Committee within the Agency and appointed by the ICN Project Director will read the proposals, conduct reference checks, score the proposals, and make a written recommendation to the Commissioner of the Agency. This includes determining whether the Contractor has met the standards of responsibility. In determining responsibility, the ICN Project Director may consider factors such as, but not limited to, the Vendor's specialized expertise, ability to perform the work, experience and past performance. Such a determination may be made at any time during the evaluation process and through contract negotiation if information surfaces that would result in a determination of non-responsibility. If a Vendor is found non-responsible, a written determination will be made a part of the procurement file and mailed to the affected Vendor.

The Agency reserves the right to contact any Vendor submitting a proposal for the purpose of clarifying issues in that Vendor's proposal. The Agency advises Vendors to clearly designate in their proposal a point-of-contact for questions or issues that arise in the Agency's review of a Vendor's proposal.

The Agency may change the size or composition of the committee during the review in response to exigent circumstances. The Agency's Evaluation Committee will score the proposals using the scoring system criteria and weighted percentages below. The highest score that can be awarded to any proposal is 100 points.

Contractor Experience and Capabilities: 10%
Scope of Work:75%
References: 5%
Price: 10%

The Evaluation Committee's review will include the following topics: Place of Business and Hours of Operations, Vendor Experience and Capability, Key Personnel, Operational Support Staff, HCBS Case Management, Medical Case Management, Case Manager Training, Education and Outreach, Single Point of Entry and Supportive

Services, ICN Network Requirements, Claims Processing, Data to Support Case Management Activities, Reporting, and Technical Infrastructure and Reporting.

Contractors must provide narrative responses addressing these topics including how they intend to complete the requirement, what problems/issues need to be resolved, what assistance will be needed from the Agency, who will execute the requirement, and any additional information the Contractors would like to submit.

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

The ICN may develop and distribute marketing materials, with approval from the Agency.

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

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

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

2. Details

a. **Scope of Marketing**

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

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

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

The ICN may not directly market to individual Medicaid recipients, as specified below, and must adhere to the requirements specified by 42 CFR § 438.104. The ICN is prohibited from door-to-door, telephonic or other cold-call marketing or engaging in marketing activities that could mislead, confuse or defraud Medicaid recipients, enrollees or potential Enrollees. Marketing materials cannot contain any assertion or statement whether written or oral that:

- *Potential enrollees must enroll with the Contractor in order to obtain benefits or in order not to lose benefits; or*
- *ICN is endorsed by CMS, the Federal or State government or similar entity*

When distributing approved marketing materials, the ICN must distribute the materials throughout the entire state.

The ICN's marketing activities and materials must not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

The ICN may only conduct marketing activities in health care settings in common areas, such as cafeterias, recreational rooms, or conference rooms. The ICN may not conduct marketing activities in areas where enrollees primarily receive health care services, or wait to receive health care services. Areas where the ICN is prohibited from conducting marketing activities include, but are not limited to, the following:

- *Waiting rooms*
- *Exam rooms*
- *Hospital patient rooms*
- *Areas within a nursing facility where enrollees receive health care or functional assistance*
- *Areas within an adult day health services facility where enrollees receive health care or daily scheduled activity programming*
- *Dialysis center treatment areas*

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

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3._X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The ICN must translate written marketing materials into prevalent non-English languages.

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

i. The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii. The languages comprise all languages in the service area spoken by approximately percent or more of the population.

iii._X_ Other (please explain):
The prevalent non-English languages are defined, at minimum, as the top fifteen (15) languages spoken in the State by individuals with Limited English Proficiency.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

The Agency will develop the model enrollee handbook and the ICN may request additions or modifications to the enrollee handbook (which must be approved by the Agency prior to the distribution of the enrollee handbook). The Agency will distribute the enrollee handbook to ICN enrollees. The Agency will also develop enrollee notices, any applicable provider directories, and any other material necessary for the enrollee's use and/or understanding of the ICN program

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

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

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

2. Details.

a. Non-English Languages

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

The State defines prevalent non-English languages as:
(check any that apply):
1. __ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. The languages spoken by approximately_ percent or more of the potential enrollee/ enrollee population.
3. Other (please explain):
The Prevalent Non-English Languages are defined as, at a minimum, the top fifteen (15) languages spoken in the State by individuals with limited English proficiency.

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

The ICN will direct enrollees, upon request, to the Agency's free of cost oral interpretation services as provided through its toll-free recipient call center.

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

The Alabama Medicaid website includes program information regarding the ICN program. As described above, the Agency will develop the model enrollee handbook that describes the ICN program and will distribute the enrollee handbook to ICN enrollees.

The ICN is also required to offer education to individuals potentially eligible for the ICN program that equips them with knowledge sufficient to make informed choices about Medicaid-funded LTSS. The ICN is also required to offer other support to assist individuals potentially eligible for the ICN program with the Medicaid application process and the process to seek certification for LTSS, as applicable.

The Agency will also require the ICN to have a toll-free telephone line, which must be staffed during Business Days between 8:00 a.m. and 5:00 p.m., that allows toll-free calls from providers and enrollees to provide health-related support and access. The ICN's telephone line staff must be trained to respond to questions about the ICN Program, including questions regarding medical and HCBS case management and questions regarding LTSS options for Medicaid-eligible individuals.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

__ State
___ contractor (please specify):

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

c. Enrollee Information

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

(i) _ X_ the State

(ii) ___ State contractor (please specify):

(iii) _X__ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

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

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

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

The Agency will have mechanisms in place to educate Medicaid recipients eligible for the ICN program about the ICN program. The Alabama Medicaid website includes program information regarding the ICN program. As described above, the Agency will develop the model enrollee handbook that describes the ICN program and will distribute the enrollee handbook to ICN enrollees.

b. **Administration of Enrollment Process**.

__X_ State staff conducts the enrollment process.

The Agency will identify Medicaid recipients eligible for the ICN program and will automatically enroll them into the single ICN. ICN enrollment will be mandatory for all eligible Medicaid beneficiaries, with the exception of tribal members. The Agency will passively enroll tribal members into the ICN and provide them the opportunity to opt out of the ICN program. On a monthly basis, the Agency or its designee will send the ICN a file with the list of ICN enrollees.

The Agency will send new enrollees a letter notifying them of their enrollment in the ICN program. Tribal members will have the option to opt-out of the ICN program. The letter to tribal members will include information about their eligibility. Tribal Members can opt out at any time. There are 38 Tribal Members in the ICN target population.

In addition, the ICN must have a systematic approach to identify enrollees in need of medical case management and to deliver medical case management services to those enrollees. The Agency will review and approve the ICN's policies and procedures defining its medical case management activities, including the criteria for enrollees to receive medical case management services.

For each enrollee that the ICN identifies as in need of medical case management services, the ICN will mail the enrollee a letter with information about the medical case management program and the name and contact information for the enrollee's assigned Medical Case Manager. The ICN must assist enrollees to change their Medical Case Manager, upon request.

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

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

Broker name:

Please list the functions that the contractor will perform:

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

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

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

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

All individuals eligible for the ICN program will be enrolled in the ICN by October 1, 2018 and will receive a letter notifying them of their enrollment by September 1, 2018. The ICN will begin delivering services statewide on October 1, 2018.

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

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

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

_X The State **automatically enrolls** beneficiaries

They Agency will automatically enroll eligible beneficiaries into the single ICN on a statewide basis. Tribal members will have the option to opt-out of the ICN program. The letter to tribal members will include information about their eligibility. Tribal Members can opt out at any time. There are 38 Tribal Members in the ICN target population. Letters will be sent by September 1, 2018.

The Agency will send new enrollees a letter notifying them of their enrollment into the ICN program.

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:

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

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

_X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

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

i._X_ Enrollee submits request to State.

An enrollee may disenroll for cause at any time. The following constitute cause for disenrollment:

- *Enrollee moves out of State*
- *The ICN does not, because of moral or religious objections, cover the service the Enrollee seeks;*
- *The Enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;*
- *Other reasons, including but not limited to poor quality of care, lack of access to services covered by the ICN or lack of access to providers experienced in dealing with the enrollee's health care needs*

An enrollee may disenroll without cause if the Agency imposes sanctions on the ICN.

In addition, tribal members may disenroll from the ICN program at any time.

If an enrollee disenrolls from the ICN program, the Agency will continue to provide and pay for HCBS Case Management through the fee-for-service

system under the 1915(c) waiver service. The enrollee will no longer receive the medical case management provided by the ICN.

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

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

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

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

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

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

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

The ICN may request disenrollment of an enrollee if the enrollee's utilization of services is fraudulent or abusive or if the enrollee is disruptive, unruly, threatening or uncooperative to the extent that enrollee's continued enrollment with the ICN seriously impairs the ICN's ability to provide services to the enrollee or other enrollees, and the enrollee's behavior is not caused by a physical or behavioral health condition or other special needs.

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

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

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

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

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at45 CFR Parts 160 and 164.

E. Grievance System

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

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

In accordance with the concurrent approved1915c waivers, Control Numbers AL 0068 and 0878, a Notice of Action is sent by certified mail in addition to the Case Manager communicating the information to the enrollee.
The applicant/participant has 30 days from the date on the Notice of Action. Alabama Department of Senior Services schedules the Informal Conference within 30 days. There is normally a two week review period at AMA unless additional documentation/information was requested. After AMA sends the decision letter to the applicant/participant they have 30 days from the date of that letter to request a Fair Hearing.

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

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

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

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

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

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

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

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

b. Timeframes

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

___ The State's timeframe within which an enrollee must file a **grievance** is _ days.

c. Special Needs

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

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

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

_X_ The grievance procedures is operated by:
__X_ the State

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

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

Grievances

Grievances will be reviewed and addressed by the State. Grievances can be filed with the Alabama Medicaid Agency in writing or verbally. Enrollees can request assistance with filing a grievance from the following parties:

- *Medical or HCBS case manager*
- *The Office of the Ombudsman*

Upon submitting a grievance, the State will investigate complaints. Appropriate parties must initiate action within 24 hours if it appears that a participant's health and safety are at risk. If necessary the complainant will be interviewed.

A summary and plan of correction will be sent from the State for all complaints reported within thirty (30) days of the request for the summary or plan of correction. The providers must forward their plan of corrections to the State. The State will evaluate the plan of correction within seven (7) days of receipt. If the plan of correction is not responsive to the complaint, it will be returned to the provider within two (2) days. The revised plan of correction will be resubmitted to the State within two (2) working days. If the summary or plan of correction carried out is found not to be responsive, the provider will have up to forty-five (45) days to revise the plan and carry out the appropriate action.

Dispute Resolution

The State does operate another dispute resolution process--the informal conference process, which offers participants the opportunity to appeal decisions that adversely affect their services, while preserving their right to a fair hearing provided by the State. An individual choosing to use the informal conference to resolve a dispute is informed in writing by the HCBS Case Manager that if the informal conference decision is not favorable, they maintain their right to have a fair hearing under 42 C.F.R. Part 431 Subpart E.

At the conference, the participant may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice. If the dispute is not resolved through the informal conference, the participant, applicant, or his/her legal representative can submit a written request for a fair hearing within 30 days of the date of the notice of action.

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

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

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

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

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

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

___ Other (please explain):

F. Program Integrity

1. Assurances.

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

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

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

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

II. Details of Monitoring Activities

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

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

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

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

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

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

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

c. __X___ Consumer Self-Report data

___ CAHPS (please identify which one(s))
___ State-developed survey:
___ Disenrollment survey
___ Consumer/beneficiary focus groups
_X NCI-AD Survey

Consumer Self-Report Data
Applicable Program: *ICN*
Personnel Responsible: *Agency Staff*

Detailed Description of Strategy/Yielded Information: *Starting in 2019, the Agency anticipates using the National Core Indicators-Aging and Disabilities (NCI-AD) consumer experience survey to assess performance in its Elderly and Disabled and ACT waivers, as well as the TA and SAIL waivers (participants in the TA and SAIL waivers are not included in the ICN program). The NCI-AD survey includes standard measures used across states to assess the outcomes of services provided to individuals and families. This survey addresses key areas of concern including service planning, rights, community inclusion, choice, access, health and care coordination, safety and relationships. The Agency will use the survey results to design and implement quality improvement strategies and evaluate ICN performance for enrollees receiving services under the Elderly and Disabled and ACT waivers. These measures will also be used to compare the ICN population to similar populations not receiving ICN services.*
Frequency of Use: *Annually*
How it yields information about the area(s) being monitored: *The NCI-AD survey will be used to measure program integrity, timely access, coordination and continuity of care and quality of care.*

d. __X___ Data Analysis (non-claims)
___ Denials of referral requests
_X Disenrollment requests by enrollee
_X From plan
___ From PCP within
__X_ Grievances and appeals data
___ PCP termination rates and reasons
_X_ Other (please describe): *Medical Case Management Reports and HCBS Case Management Reports*

Disenrollment requests by enrollee:

Applicable Program*: ICN*
Personnel Responsible: *Agency staff*
Detailed Description of Strategy/Yielded Information: *Enrollees will be required to request ICN disenrollment from the Agency. The Agency will monitor these requests to assess the reason for disenrollment, as well as trends in the rate of disenrollment.*
Frequency of use*: Ongoing*
How it yields information about the area(s) being monitored: *This data analysis activity will be used to monitor disenrollment of ICN enrollees. They Agency will assess the raw number of disenrollments, rate of disenrollment, reason for disenrollment and trends in disenrollment. The Agency will use this information to address issues with the ICN on an ongoing basis.*

Grievance System

Applicable Program: *ICN*
Personnel Responsible: *Agency Staff*

Detailed Description of Strategy/Yielded Information: *The Agency will maintain a grievance system under which ICN enrollees may submit grievances regarding the ICN and the ICN program.*
Frequency of Use: *The Agency will make grievance data available quarterly to the ICN.*
How it yields information about the area(s) being monitored: *The Agency will monitor the reason for each grievance associated with the ICN program, and will determine if any action is required to resolve the grievance. The Agency will monitor the number of grievances associated with the ICN program and any trends in the types of grievances over time.*

Medical Case Management Reports
Applicable Program: *ICN*
Personnel Responsible: *ICN staff*
Detailed Description of Strategy/Yielded Information: *The Agency will require the ICN to complete medical case management reports to monitor the medical case management activities. The medical case management report will cover the number of enrollees assigned to each Medical Case Manager, number of contacts, and descriptive information about the medical case management services provided.*
Frequency of use*: Monthly*
How it yields information about the area(s) being monitored: *These reports will monitor case management activities. The Agency will review the reports to monitor the caseload and frequency of enrollee contacts. The Agency will also review the types of medical case management services provided. The services provided are an indicator of the ICN's engagement in medical case management and providing preventive care.*

HCBS Case Management Reports
Applicable Program: *ICN*
Personnel Responsible: *ADSS staff*
Detailed Description of Strategy/Yielded Information: *The Agency will require ADSS to complete HCBS case management reports to monitor HCBS case management activities. The HCBS case management report will cover HCBS Case Manager assignments, caseload, and enrollee contacts.*
Frequency of use*: Monthly*
How it yields information about the area(s) being monitored: *These reports will monitor case management activities. The Agency and ICN will review the reports to monitor the caseload and frequency of enrollee contacts*

e. _____ Enrollee Hotlines operated by State:

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that

they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. _____ Geographic mapping of provider network

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

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

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

k. _____ Ombudsman

l. __X___ On-site review:

Applicable Program*: ICN*
Personnel Responsible*: Agency staff and ICN*
Detailed Description of Strategy/Yielded Information*: On-site reviews will be conducted both for the readiness assessment and ongoing monitoring. On-site reviews will include review of ICN materials, including systems and policies and procedures regarding program integrity and coordination and continuity of care. On-site reviews will also include interviews with program and case management staff.*
Frequency of Use*: During the readiness assessment and annually thereafter.*
How it yields information about the area(s) being monitored: *On-site reviews will include review of systems and policies and procedures related to program integrity and coordination and continuity of care. Agency staff will observe medical and HCBS case management staff to monitor that they adhere to approved policies and procedures for conducting case management activities. Agency staff will also review systems for processing and paying for HCBS case management services, if applicable.*

m. _____ Performance Improvement projects [**Required** for MCO/PIHP]
___ Clinical
___ Non-clinical

n. __X___ Performance measures [**Required** for MCO/PIHP]
__ Process
__X Health status/outcomes
__X__ Access/availability of care
__X__ Use of services/utilization

____ Health plan stability/financial/cost of care
____ Health plan/provider characteristics
____ Beneficiary characteristics

***Applicable Program**: ICN*
***Personnel Responsible**: Agency staff and ICN*
***Detailed Description of Strategy/Yielded Information:** The Agency will use a combination of HEDIS, Nursing Home Compare. and home grown measures, as listed in Attachment F of the ICN RFP, to monitor the quality of care provided, by assessing participant health status, access and availability of care and use of services or utilization. Measures will also be used to compare the ICN population to similar populations not receiving ICN services.*
***Frequency of Use**: Annually*
***How it yields information about the area(s) being monitored:** These measures will be used to monitor timely access and quality of care.*

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

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

q. ____ Provider Self-report data
___ Survey of providers
___ Focus groups

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

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

***Applicable Program:** ICN*
***Personnel Responsible:** Agency and ICN staff*
***Detailed Description of Strategy/Yielded Information:** The ICN must review utilization information and data provided by the Agency to detect under-utilization, over-utilization and mis-utilization with a focus on preventive care, emergency department and inpatient utilization.*
***Frequency of Use:** Ongoing*
***How it yields information about the area(s) being monitored:** Utilization reviews will be used to evaluate the quality of care provided to ICN participants by monitoring the under-, over- and mis-utilization of services.*

t. __X___ Other: (please describe): Desk Review

***Applicable Program:** ICN*

Personnel Responsible: *Agency staff*
Detailed Description of Strategy/Yielded Information: *The Agency conducts desk reviews as part of the ICN readiness assessment to confirm the ICN's policies and procedures, and enrollee materials adhere to the contract and comply with federal regulations. The ICN must pass the readiness assessment process prior to accepting enrollees, receiving monthly payments, or providing case management services. In addition, the Agency will conduct ongoing desk reviews to monitor the ICN's continued compliance with the contract and federal regulations.*
Frequency of Use: *During the readiness assessment (prior to enrolling individuals, payment, or providing services) and ongoing.*
How it yields information about the area(s) being monitored: *The Agency will conduct desk reviews to evaluate ICN materials, policy and procedures, education materials, and other documents. The review will include ICN documents related to the following areas: marketing, participant choice of case managers, enrollment and disenrollment, program integrity, information to enrollees, coordination and continuity of care, and quality of care.*

Section C: Monitoring Results

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

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

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

___ This is a renewal request.

- ___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ___ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy:

Confirmation it was conducted as described:

___ Yes

___ No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

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

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: __Flake Oakley _____

c. Telephone Number:___334-353-3310_____

d. E-mail:flake.oakley@medicaid.alabama.gov_____

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

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

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

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

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

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

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

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

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

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

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

Capitation portion will be for a PCCM entity and will cover the combination of current HCBS case management and the incremental case management costs over and above what is currently expended in today's 1915c waiver system.

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. _X_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1. _X_ First Year: *$98.92* per member per month fee
2. _X_ Second Year: *$101.39* per member per month fee
3. ___ Third Year: *$106.45* per member per month fee
4. ___ Fourth Year: $*111.80* per member per month fee
5. ___ Fifth Year: $*117.39* per member per month fee

Figures above are in total. Actual payments will vary by population type and are shown below for P1.

The amendment to the cost effectiveness coincides with the contract amendment submitted by Alabama for this program. Included in the table are PMPMs for P2-P5

	Current 1915c case management PMPM	*Incremental 1915b case management PMPM*	*Total PMPM*
P1: 10/1/2018 – 9/30/19			
Nursing Facility	*$0.00*	*$18.19*	*$18.19*
HCBS	*$264.86*	*$18.19*	*$283.05*
TOTAL	*$80.73*	*$18.19*	*$98.92*
P2: 10/1/2019 – 9/30/2020			
Nursing Facility	*$0.00*	*$18.64*	*$18.19*
HCBS	*$271.48*	*$18.64*	*$290.13*
TOTAL	*$82.75*	*$18.64*	*$101.39*
P3: 10/1/2020 – 9/30/2021			
Nursing Facility	*$0.00*	*$19.58*	*$19.58*
HCBS	*$285.02*	*$19.58*	*$304.60*
TOTAL	*$86.87*	*$19.58*	*$106.45*
P4: 10/1/2021 – 9/30/2022			
Nursing Facility	*$0.00*	*$20.56*	*$20.56*
HCBS	*$299.34*	*$20.56*	*$319.90*
TOTAL	*$91.24*	*$20.56*	*$111.80*
P5: 10/1/2022 – 9/30/2023			
Nursing Facility	*$0.00*	*$21.59*	*$21.59*
HCBS	*$314.31*	*$21.59*	*$335.90*
TOTAL	*$95.80*	*$21.59*	*$117.39*

The PCCM entity PMPM is estimated for each year and are shown in columns X-

AE of Appendix D5. The incremental amount is shown in columns AB-AE of Appendix D5. As a part of the procurement process, this PMPM amount has been bid upon by the responding vendors for years 1 through 5. The $18.19 PMPM for incremental 1915b case management are new expenditures anticipated to be $5,000,000. The PCCM entity's achievement of the targeted nursing facility mix will generate the State Plan savings required to fund these new costs.

The P2-P5 figures are based on the ICN contract amendment.

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

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

The PCCM entity will have the ability to earn incentives based on the actual mix of nursing facility and HCBS enrollees each year of the program as compared to a target mix. Additionally, the PCCM entity will be at risk for some portion of the PMPM if the target mix is not achieved. The State intends to achieve this through a PMPM payment withhold. For Appendix D, we have assumed that the PCCM entity will improve the mix by 2.6%. This will achieve the target mix shift of 0.6% plus will trigger the maximum incentive of $2.150 million per 1.0% improvement over and above the target mix (up to $4.3 million maximum). The savings generated from the PCCM entity impacting the mix will create savings to State Plan service costs that will offset both the incentive payments and the additional 1915(b) case management costs included in the PMPM. To the extent that the PCCM entity beats the target mix as assumed in our projection, the incentive will be made up of only a portion of the additional State Plan service savings created from the shift in mix.

Amendment #2 includes changes to the incentive maximum for SFY2022 (P4) and SFY2023 (P5). The incentive maximum increased from the $4.30 million to $4.88 million. The P4 and P5 figures are based on the ICN contract amendment effective October 1, 2021.

Projection Period	***Original Incentive Max***	***Amendment #2 Incentive Max***	***Difference***
P1 – SFY2019	*$4,300,000*	*$4,300,000*	*-*
P2 – SFY2020	*$4,300,000*	*$4,300,000*	*-*
P3 – SFY2021	*$4,222,142*	*$4,222,142*	*-*
P4 – SFY2022	*$4,300,000*	*$4,880,000*	*$580,000*
P5 – SFY2023	*$4,300,000*	*$4,880,000*	*$580,000*

The adjustments for P4 and P5 are included in Appendix D.5 (column U).

d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a._X_ Population in the base year data

1._X_ Base year data is from the same population as to be included in the waiver. *Medicaid Eligibility Group's (MEG's) will include Nursing Facility Dual, Nursing Facility Non-Dual, Home & Community Based Waiver Dual, and Home & Community Based Waiver Non-Dual.*

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

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

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
A typical overall annual enrollment growth of 2.0% has been assumed for P1 and P2. This increase is based on population national projections for the 80 years of age and older population.
Member month projections at the MEG level are anticipated to increase/decrease separate from typical enrollment growth as a result of ICN management and their impact on diverting enrollees to the HCBS setting. The prospective period includes increases in the HCBS MEGs for each prospective period quarter and decreases in the Nursing Facility MEGs for each prospective period quarter.

This amendment to the 1915(b) cost-effectiveness uses the existing P1-P2 assumptions to project P3-P5.

d. _X_ [Required] Explain any other variance in eligible member months from BY to P2:
Please see response to Section D.I.E.c.

e. _X_ [Required] List the year(s) being used by the State as a base year: *SFY17.* If multiple years are being used, please explain:
N/A

f. _X_ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period
State Fiscal Year (SFY) spanning October 1, 2016 through September 30, 2017.

g. _X_ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
Although small for this population, hospital access/supplemental payments are paid outside of the State's MMIS fee-for-service claims data and are added as an

adjustment to the claims data. These are supplemental payments to hospitals that bring dollars from the per diem amounts paid to hospitals up to the UPL. They are applicable only to the non-dual MEGs for this waiver.

For Conversion or Renewal Waivers:

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

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

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

_____

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

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

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

For Initial Waivers:

a._*X*_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account. *There are no exclusions of any services from the cost effectiveness analysis.*

For Conversion or Renewal Waivers:

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

_____

_____

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

_____

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

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

For Initial Waivers:

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

any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
MMIS operating cost and program administration salaries and benefits	*Savings from change in nursing facility mix*	*12% or $518k*	*Base admin plus additional admin: $17.68 PMPM in P1 or $4.8m*

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

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. ***Note: this is appropriate for MCO/PCCM programs.***

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. ***Note: this is appropriate for statewide PIHP/PAHP programs.***

c.__X_ Other (Please explain). *The State allocates base administrative cost based on direct cost for existing 1915c services supporting salaries and benefits and its Public Assistance Cost Allocation Plan (PACAP) for other administrative cost. A summary of the base costs and projections are shown in the table below. Please note the PACAP increases significantly from BY (FY17) to P1 (FY19) due to the anticipated required improvements to the MMIS system.*

	BY $s	*BY PMPM*	*TREND (ANNUAL)*	*P1 $s*	*P1 PMPM*
Direct Existing Admin	*$1.3m*	*$4.59*	*4.0%*	*$1.4m*	*$4.97*
PAPAC Allocation	*$1.9m*	*$6.86*	*25.6%*	*$2.9m*	*$10.82*
Total	*$3.2m*	*$11.45*	*17.4%*	*$4.3m*	*$15.79*

The total administrative $15.79 PMPM in P1 or $4.3m.

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected

in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

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

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

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

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

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

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed

certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

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

1._-_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2._*X*_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.

Each year, the State will establish a target mix of nursing facility and HCBS enrollees. The target mix may vary depending on actual enrollment growth but is currently assumed to be an improvement in the mix of 0.6%. Currently, the nursing facility target mix will be based upon the actual historical mix for the previous 12-month time frame ending 6 months prior to the target timeframe minus 0.6%. For this waiver, we have used the FY17 baseline mix of 69.5% and a target mix of 68.9% for P1. The shift in mix is expected to result in savings with a larger portion of the

population residing in the less expensive HCBS setting.

An incentive pool will be established based on an estimated $2.150 million for each percentage reduction in the nursing facility mix below the target, with a maximum incentive of $4.3 million. Each 1.0% reduction is projected to generate approximately $7-$9 million in overall savings.

Membership mix will be monitored over time to ensure that the portion of the PCCM entity PMPM that are new expenditures is no more than the savings achieved from the shift in mix. The State intends to withhold a portion of the PMPM which will be released to the PCCM entity upon achieving the targeted mix. If the PCCM entity achieves a mix creating savings over and above the targeted mix, an incentive will be available The State has assumed in the waiver projections that the PCCM entity will earn the maximum $4.3 million (2%) incentive.

ii. Document the method for calculation incentives/bonuses, and
Please see response to Section D.I.H.D.2.i.

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.
Please see response to Section D.I.H.D.1.iii.

Current Initial Waiver Adjustments in the preprint

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

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

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

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

1. _X_ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)*. The actual trend rate used is: *_2.7% in total_*. Please document how that trend was calculated: *Actual cost data over time was analyzed to determine the trend rate. Trend development utilizes 3, 6, and 12-month moving averages (MMA) over the course of the base data period.*

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

   i. _*X*_ State historical cost increases. Please indicate the years on which the rates are based: base years*__SFY14-SFY17___* In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. *Please see response below to D.I.I.a.3.ii.*

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

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

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

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

The following explains the rationale used for the state plan services trend adjustment.

We utilize a combination of the items listed in D.I.I.a. We look at historical Alabama Medicaid average annual trend data for the ICN population spanning SFY14 through SFY17. This is done by population group (nursing facility, type of waiver, dual/non-dual), service category (nursing facility, waiver, inpatient, outpatient, PCP, Rx, etc.), and separately for utilization per thousand and unit cost (which are combined for per member per month trends). We do adjust for changes in enrollment mix when reviewing trends.

Additionally, please note that in developing trend, the historical data includes program changes such as nursing home rate increases and HCBS fee increases. Because of this, we are confirming that the program adjustment section is not

filled in for fee increases, to ensure no duplication of these items. Trends were developed at the category of service and broad rate cohort level.

In addition to actual historical Alabama Medicaid trends, we reviewed other State trends for benchmarking purposes for similar populations as well as national trend studies such as the Consumer Price Index (CPI) and Producer Price Index (PPI).

A combination of the above data points is used to guide prospective trend assumptions from BY to P1 and P2.

Please note that anticipated changes in fee schedules are included in the unit cost component of the prospective trends.

Trend Revisions as part of Amended Cost Effectiveness
Dual Eligible Nursing Facility Trends for P3, P4 and PY5 trends have been updated from the trends established for P1 and P2. Due to anticipated reductions in annual cost of living adjustment for P3 and it's influence on patient responsibility component of nursing home costs, it is expected that the unit cost trend for net nursing home component reimbursed by the Medicaid Agency will increase. The annual increase in the patient liability will not reduce the cost to the Medicaid agency associated with the normal annual inflation. The increase for P3 trend for the NF Dual MEG is 0.3% and the annual trend for P3 forward is 2.6%. This changes the overall trend for all MEGs combined in P3 through P5 from 2.7% to 3.0%.

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

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____ Determine adjustment for Medicare Part D dual eligibles.
E.____ Other (please describe):
As described in D.I.I.A.3, these changes are included within the unit cost trend projections.

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

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____ Other (please describe):
N/A

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____ Other (please describe):
N/A

v.__*X*__ Other (please describe):
A._____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B._____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C._____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____*X*__Other (please describe): *A programmatic change was included for an anticipated increase in the acuity of the HCBS and nursing facility populations for each year. This adjustment was an increase of 0.6% for P1 and an increase of 0.3% for P2.*

The increase in the acuity of the HCBS and nursing facility populations reflects the deflected population that would have been in the nursing facility in the absence of the waiver. Those deflected individuals are assumed to require more services than those traditionally in the HCBS setting. In contrast, those deflected individuals are assumed to require less services than those traditionally in the nursing facility setting.

This adjustment was derived using Alabama Medicaid data. The historical HCBS and nursing facility populations were split into three PMPM tiers each. The total PMPM for HCBS and nursing facility duals and HCBS and nursing facility non-duals was derived using the assumed enrollment in the absence of the waiver as compared to the assumed enrollment under the waiver. The additional individuals deflected into the HCBS setting from the enrollment projection were assumed to be in the higher tier 2 and 3 PMPM groups for HCBS calculation due to their assumed higher acuity levels. In contrast, the individuals deflected into the HCBS setting from the enrollment projection were assumed to be in the lower tier 1 and 2 PMPM groups for nursing facility calculation due to their assumed lower acuity levels.

Nursing Facility Per Diem Increase

Effective March 1, 2020, Alabama implemented a $20.00 per day increase for nursing homes. This increase is due to the COVID-19 health emergency. As outlined in the bulletin published on Alabama Medicaid's website, the nursing facility per diem increase is effective for dates of service between March 1, 2020 through the end of the COVID-19 health emergency.

At the time of this amendment the end date for the COVID-19 health emergency is unknown. The cost-effectiveness amendment assumes that the COVID-19 emergency and increased unit cost will expire on 9/30/2021.

The adjustment was derived based on the nursing facility unit cost represented in the base year of the cost-effectiveness. The unit cost impact was developed separately for dual eligible and Medicaid only MEGs. The impact applicable to P2 varies from the impact for P3.

Amended P2 projections include 7 months or 214 days of the fee increase. The 214 days represent the number of calendar days between 3/1/2020 and 9/30/2020.

Amended P3 projections include 5 months or 151 calendar days of the impact.

The two years impacts vary because the cost-effectiveness P3 is developed by trending and adjusting P2. Therefore, it's appropriate to apply only an incremental adjustment to P2 and the remaining

incremental adjustment to P3.

The value of the adjustment for the nursing home COVID-19 program change impact is outlined in the following table:

	P2	*P3*	*P4*
NF Dual	*6.55%*	*4.62%*	*-10.13%*
NF Non-Dual	*4.01%*	*2.83%*	*-5.89*

P4 adjustments are negative to remove the program change applied in P2 and P3 and adjusted for the impact of trend.

	Adjustment Included in Original Cost-Effectiveness	*Impact of Nursing home COVID-19 per diem increase*	*Aggregate Program Change Impact*
Period P2 (October 1, 2019 – September 30, 2020)			
NF Dual	*0.1%*	*6.5%*	*6.6%*
NF Non-Dual	*0.6%*	*4.0%*	*-2.7%*
HCBS Dual	*1.2%*	*n/a*	*0.3%*
HCBS Non-Dual	*1.0%*	*n/a*	*-16.3%*
Period P3 (October 1, 2020 – September 30, 2021)			
NF Dual	*0.2%*	*4.6%*	*4.8%*
NF Non-Dual	*0.9%*	*2.8%*	*3.7%*
HCBS Dual	*1.6%*	*n/a*	*1.6%*
HCBS Non-Dual	*1.4%*	*n/a*	*1.4%*
Period P4 (October 1, 2021 – September 30, 2022)			
NF Dual	*0.2%*	*-10.3%*	*-10.1%*
NF Non-Dual	*0.9%*	*-6.8%*	*-5.9%*
HCBS Dual	*1.5%*	*n/a*	*1.5%*
HCBS Non-Dual	*1.3%*	*n/a*	*1.3%*

n/a indicates no adjustment.

Nursing Facility Per Diem Change – Amendment #2

The Nursing Facility per diem change included in Amendment #1 reflected an additional $20 per diem through P3. The prior amendment cost effectiveness assumed that the $20 per diem would expire beginning P4 based on the assumed ending to the PHE.

Amendment #2 reflects the elimination of the $20 per diem in lieu of updated nursing home rates effective July 1, 2021. This nursing fee schedule change impacts the cost-effectiveness projections for the 4th quarter of P3 (October 1, 2020 – September 30, 2021), P4 (October 1, 2021 to September 30, 2022). P5 values are not adjusted since projections are based on P4 projections. The basis for the nursing fee schedule change is the annual nursing facility reimbursement update in accordance with Alabama Administrative Code Chapter 22.

The adjustment was derived by calculating the impact of the rebased nursing facility per

diems for dual and non-dual populations for nursing facility utilization and expenditures for the period between July 1, 2020 and June 30, 2022. The adjusted nursing facility impact was applied to overall expenditures for each MEG to develop the adjustment applicable to each MEG below.

P3 adjustments reflect only one-quarter of the fee increase while P4 includes the remaining three-quarters of the fee change that discounts the trend adjustment for for each MEG from P3 to P4..

NF Per Diem Adjustment (Effective July 1, 2021)

MEG	*P3*	*P4*
NF Dual	*2.9%*	*8.4%*
NF Non-Dual	*2.2%*	*6.4%*

The aggregate Initial, Amendment #1 and Amendment #2 Program Change Projections reflected in in Appendix D5 for P3 and P4 are outlined in the following table.

Appendix D.5 Program Change Projection including NF Per Diem Adjustment

MEG	*P3*	*P4*
NF Dual	*7.8%*	*8.6%*
NF Non-Dual	*6.2%*	*7.4%*

HCBS dual and non-dual MEG's are not impacted by this change.

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

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

2.__X An administrative adjustment was made.

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

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

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

C.____ Other (please describe):

ii._ X FFS cost increases were accounted for.

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

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

C. __X Other (please describe): *New administrative expenditures that will result from this waiver are included. MMIS operating cost and program administration salaries and benefits are shown as the administration program change under P1. Savings from the change*

in nursing facility mix will more than offset these new expenditures. We have additionally included an average annual trend of 4.0% for State administrative PMPM expenditures from P1 to P2.

As discussed in Section D.I.G.c, the State allocates base administrative cost based on direct cost for existing 1915c services supporting salaries and benefits and its Public Assistance Cost Allocation Plan (PACAP) for other administrative cost. The direct existing costs are trended at 4.0% annually. Please note the PACAP increases significantly from BY (FY17) to P1 (FY19) due to the anticipated required improvements to the MMIS system. These increases would occur in the absence of this waiver.

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

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

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

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

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

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

i. State Plan Service trend

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

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

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

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

3. Explain any differences:

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

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

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

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

Method:

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1. _X_ Payments outside of the MMIS were made. Those payments include (please describe): *Although small for this population, hospital access/supplemental payments are paid outside of the State's MMIS fee-for-service claims data and are added as an adjustment to the claims data. These are supplemental payments to hospitals that bring dollars from the per diem amounts paid to hospitals up to the UPL. They are applicable only to the non-dual MEGs for this waiver. This adjustment is included in the Base Year and is included in the*

expenditures in Appendix D3; Column E.

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.

3._*X*_ The State has not made an adjustment because the same copayments are collected in managed care and FFS.

4.___ Other (please describe):

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

1._*X*_ No adjustment was necessary and no change is anticipated.

2__ _ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine copayment adjustment based on pending SPA.

3.___ Determine copayment adjustment based on currently approved copayment SPA.

4.___ Other (please describe):

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

Basis and method:

1.___ No adjustment was necessary

2._*X*_ Base Year costs were cut with post-pay recoveries already deducted from the database. *Both patient liability and share of cost are excluded from the base year data.*

3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4.___ The State made this adjustment:*

i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**

ii.___ Other (please describe):

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

1. _X_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3. ___ Other (please describe):

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

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

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

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

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

1. _X_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ___ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. _X_ Other (please describe): *Base data included in Appendix D3 excludes cost-settlement or supplemental payments made to FQHCs/RHCs and only reflects fee-for-service payments.*

Special Note section:

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

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

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

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

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

Adjustment	Capitated Program	PCCM Program
	-- See the next column)	

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

1. ___Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2. ___The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. _X_Other (please describe): *The Base Year is populated on an incurred basis using DOS. Since there were 5 months of runout for the data, the data was adjusted to account for IBNR by category of service. This adjustment is already accounted for prior to bringing in the base data costs in Appendix D3. The data was deemed 99.5% complete yielding an adjustment of 0.5%.*

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

1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. _X_ This adjustment was made in the following manner: *The State anticipates paying the PCCM entity a PMPM that will include the PCCM entity's incremental case management cost and related supporting services. This payment will consist of an incremental increase over and above what is currently being done for care management as 1915c services. The incremental cost will enable the PCCM entity to focus mainly on providing an enhanced ability for new members entering the system to be served in the home and community-based services setting rather than the nursing facility setting. Based on the bidding included in the RFP response, the State anticipates the incremental cost included in the PMPM payment will be $5.0 million for year one and $5.1 million for year two. This adjustment is included in Appendix D5; columns AB-AE. Savings realized from the change in mix will fund these new expenditures.*

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

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

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

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

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

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

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

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

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate

used is: _____. Please document how that trend was calculated:

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

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

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

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

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

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

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

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that

States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.

- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:

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

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

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

D.____ Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

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

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

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

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

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

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

D.____ Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

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

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

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

D.____ Other (please describe):

vi.__ Other (please describe):

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

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

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

D.____ Other (please describe):

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

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

2.___ An administrative adjustment was made.

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

ii.___ Cost increases were accounted for.

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

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

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

D.____Other (please describe):

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____
3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP

or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

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

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above. *Please see appendix D5 and the sections above for explanations of all adjustments made.*

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above. *Please see appendix D6 and Section D.I.E.*

M. Appendix D7 - Summary

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

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:
Member month projections at the MEG level are anticipated to increase/decrease separate from the assumed typical overall enrollment growth as a result of ICN management and their impact on diverting enrollees to the HCBS setting. The assumed change in case load does impact the change in overall population dollars/PMPM from BY to P2.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or

the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:
Per member per month inflation assumptions are derived using the combination of assumptions for unit cost and utilization per thousand. These impact PMPM growth for each population from BY to P2.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:
Per member per month inflation assumptions are derived using the combination of assumptions for unit cost and utilization per thousand. These impact PMPM growth for each population from BY to P2.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**
In addition to the case load and PMPM trends as well as the changing mix among nursing facility and HCBS individuals, the overall rate of change from BY to P2 is impacted by the assumed HCBS and nursing facility programmatic change as well as the addition of the PCCM entity PMPM and incentive payments discussed above. To the extent that the target mix is achieved, the PCCM entity will have an opportunity for incentive payments through an incentive program, as assumed in the projections. Additionally, a portion of the PCCM entity PMPM payment will be withheld to protect the State against a scenario where the PCCM entity does not meet the target mix.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.