

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

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Instructions – see Attachment 1

# 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 Illinois** 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 MLTSS Waiver. MLTSS is an acronym for “Managed Long Term Services and Supports”. (Please list each program name if the waiver authorizes more than one program.)

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

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part \_\_\_\_\_
  - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
  - Document is replaced in full, with changes highlighted
- 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 [06/01/14](#) ending [05/31/19](#). (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 [Michelle Maher](#) and can be reached by telephone at [\(217\) 524-7478](#) or fax at [\(217\) 524-7535](#), or e-mail at [michelle.maher@illinois.gov](mailto:michelle.maher@illinois.gov). (Please list for each program)

## Section A: Program Description

### Part I: Program Overview

#### **Tribal consultation**

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

In Illinois, as of April 2013, there are 2,020 Native American / Alaskan Natives (AI/ANs) enrolled in Medicaid. Approximately, 27 of these are dual eligible beneficiaries receiving long-term institutional or home and community-based services and supports. Approximately 74% of these beneficiaries reside in the waiver service areas.

The State has a formal process for making sure that Federally recognized tribes in the State are aware of changes to the State plan or changes to Medicaid through waiver authorities. The State will send a written summary of the proposed changes, a description of the expected impact on Medicaid services to AI/ANs, and a copy of the official language being proposed, if requested, to the sole Indian Health Service (IHS) provider in Illinois – American Indian Health Services of Chicago (AIHSC). State policy dictates a two-week comment period.

On September 12, 2013, the State provided the information as described above. AIHSC replied that they had no comments on the proposal.

#### **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).*

#### Description of Waiver Program

The State is submitting to the Centers for Medicare and Medicaid Services (CMS) this 1915(b) waiver application to implement the Managed Long-term Services and Supports Waiver (waiver). On October 31, 2013, the State submitted concurrent amendments to its applicable 1915(c) home and community-based (HCBS) waivers in order to implement this waiver.

Under the waiver, in specified geographies, dual eligible beneficiaries who receive institutional (except those receiving developmental disability institutional services) or community-based long-term services and supports (through five of the State's 1915(c) waiver programs) will be required to enroll in managed care, unless they meet another exclusion. Current eligibility determination guidelines for institutional or HCBS services will not change under the waiver unless modified by the State.

Under the waiver, beneficiaries will receive the Medicaid institutional and community-based long-term services and supports (LTSS), transportation, and behavioral health services through a Prepaid Health Insurance Plan (PIHP). Waiver beneficiaries will have a choice of at least two PIHPs in a geographic area (service area).

### Background and Goals

Illinois is among the highest in institutional payments and lowest in HCBS spending as a percentage of all long-term care spending.<sup>1</sup> Using federal fiscal year (FFY) 2009 data, the CMS analysis indicates that Illinois had the eighth highest level of institutional payments nationally and the third lowest rate nationally of HCBS spending as a percentage of all long-term care spending in the State.<sup>2</sup> Full dual eligible beneficiaries accounted for approximately 68 percent of all long-term care (institutional and HCBS) spending in Illinois Medicaid in 2010. These statistics indicate that there is need in Illinois to improve care delivery for dual eligible beneficiaries and to shift long-term care utilization from institutions to the community, as appropriate.

The State's goals are to redesign the health care delivery system for dual eligible beneficiaries with a focus on:

- Improving health outcomes, care delivery, and utilization of community-based services;
- Rebalancing its Medicaid LTSS systems from a primary reliance on nursing facility services to expanded utilization of community-based services and supports; and
- Implementing Illinois Public Act 96-1501<sup>3</sup>.

In order to achieve these goals, the State designed a program that:

1. Provides beneficiaries with a choice for:
  - Better coordination of care, as members work with a team of providers to give them the best possible healthcare;
  - Opportunities for beneficiary involvement in all healthcare decisions; and
2. Incentivizes PIHPs to provide robust care coordination and increased utilization of community-based services through a reimbursement structure that encourages use of community-based programs and focuses on performance measurement.

### MLTSS Waiver

The MLTSS Waiver (waiver) will operate in two service areas in the State – the Greater Chicago service area and the Central Illinois service area. As of December 31, 2012,

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<sup>1</sup> Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement.  
<http://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf>

<sup>2</sup> Ibid.

<sup>3</sup> IL Public Act 96-1501 requires at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the Department of Health Care and Family Services (HFS) to be enrolled in a risk-based care coordination program by January 1, 2015.

there were approximately 59,000 dual eligible beneficiaries that meet the waiver eligibility criteria in the Greater Chicago and Central Illinois service areas. This accounts for approximately 40% of full-benefit dual eligible beneficiaries in these regions (There are about 147,000 dual eligible beneficiaries in these regions – 127,000 in Greater Chicago and 20,000 in Central Illinois).

Beginning in February 2014, dual eligible beneficiaries in the Greater Chicago and Central Illinois service areas will be given the option to voluntarily enroll into the Medicare-Medicaid Alignment Initiative (MMAI). Beginning in September 2014, dual eligible beneficiaries receiving LTSS in the Central Illinois and Greater Chicago service areas that have not opted out of the MMAI will be passively enrolled into a MMAI plan through auto-assignment.

Through the MMAI, the State and the Centers for Medicare and Medicaid Services (CMS) will enter into three-year contracts with MCOs that will be accountable for providing all Medicare and Medicaid benefits and services to enrollees. All MMAI enrollees will have an opportunity to opt out of the MMAI at any time. Dual eligible beneficiaries who are receiving institutional or community-based LTSS, and who opt out of the MMAI will be required to enroll in a PIHP under the waiver unless they enroll in a care coordination entity<sup>4</sup> (CCE) or meet the other eligibility exclusions. The same PIHPs will operate in both the MMAI and the waiver.

- MLTSS Waiver Care Management

Care delivery will be supported by care teams, which are tailored and personalized to meet individual care needs and focused on providing a multidisciplinary approach to care delivery and care coordination. PIHPs will be required to provide care coordination services that identify opportunities for and provide care management to support independence in the community, and ensure effective linkages and coordination between providers and services. PIHPs will be required to assure access to HCBS waiver services when appropriate. PIHPs will be required to coordinate and provide referrals to ensure that an enrollee's treatment plan is holistic and person-centered. In addition, PIHPs will be expected to maintain relationships with community-based organizations to focus on and ensure independence for seniors and individuals with disabilities.

PIHPs will be required to provide the full range of care coordination including HCBS waiver service planning, connecting Enrollees with local community services, and coordinating referrals for other non-covered services, such as supportive housing and other social services, to maximize opportunities for independence in the community. Current eligibility determination guidelines for institutional or HCBS services will not change under the demonstration unless modified by the State.

- Monitoring and Oversight

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<sup>4</sup> Care Coordination Entity: A CCE is a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets, in order to provide care coordination services for its members.

The State is working intensively with PIHPs prior to implementation of MMAI and the waiver. Key areas oversight includes provider network; claims payment; service authorization and delivery; and data transfer. The State meets weekly with PIHPs to review network status, PIHPs' reports on the number of contracts secured with waiver providers, and to discuss additional issues such as file format exchange reviews.

The State and PIHPs will work with providers through regularly scheduled provider outreach conference calls to educate providers on billing processes and other issues prior to implementation.

During the initial months following implementation, the State will perform intensive monitoring to assure smooth implementation. Activities will include reviewing bi-weekly reports from PIHPs and bi-weekly meetings with PIHPs to discuss findings on issues such as the number of and types of complaints received; number of face-to-face contacts with enrollees; percentage of risk assessments complete; and critical incidents and follow up. On an ongoing basis, the State will require monthly reports from PIHPs and will conduct regular audits through its EQRO to ensure that PIHPs are implementing the contractual requirements.

Because the PIHPs providing services under the waiver are the same health plans providing services under the MMAI, the State will have worked intensively with PIHPs (as described above) prior to implementation of MMAI. Implementation of MMAI is expected to occur three months prior to the implementation of the waiver. Therefore, the State expects many of the operational and oversight issues to be addressed as part of the implementation of the MMAI.

- Stakeholder Involvement

The State began stakeholder outreach on its Integrated Care Program (ICP) in April 2010 through regularly scheduled stakeholder meetings. The ICP currently provides mandatory Medicaid managed care including managed long-term services and supports for the non-dual AABD population in suburban Cook and the five collar counties, and is expanding to four other regions of the state throughout 2013 and into the city of Chicago in February 2014. The State continued outreach during the development of the MMAI, holding meetings specific to mandatory enrollment of dual eligible beneficiaries receiving LTSS into managed care. The State conducts outreach and stakeholder education of its efforts through the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee, and the Seniors and Persons with Disabilities (SPD) stakeholder group. Participation generally includes beneficiaries, advocacy and community organizations, as well as MCOs. In addition to stakeholder meetings, the State uses its website to post pertinent information related to the waiver and other initiatives (<http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>) and

maintains an email box to be able to respond to questions and comments related to the waiver and the other initiatives the State is pursuing ([HFS.carecoord@illinois.gov](mailto:HFS.carecoord@illinois.gov)).

The State will continue to meet with stakeholders throughout the operation of the waiver through regularly scheduled stakeholder meetings focusing on the MMAI and well as the MLTSS waiver. A stakeholder meeting was held on April 18, 2013, and additional meetings will be scheduled through 2014. In addition, the State will maintain an email address dedicated to receiving feedback on the implementation and operation of the MLTSS waiver.

Illinois agrees to comply with the special terms and conditions (STCs) attached to this waiver to ensure compliance with statutory and regulatory compliance.

## A. Statutory Authority

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

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

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

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

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

- a. X **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. \_\_\_ **Other:** (Please provide a brief narrative description of the model.)

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

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

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

### 1. Assurances.

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

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

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

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- Two or more PIHPs.
- Two or more PAHPs.
- Other: (please describe)

### 3. Rural Exception.

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

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

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

**D. Geographic Areas Served by the Waiver**

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

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

**Less than Statewide**

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
<a href="#">Greater Chicago:</a> Cook, DuPage, Kane, Kankakee, Lake, Will, counties	PIHP	Aetna Illinicare Meridian HealthSpring Humana Blue Cross Blue Shield
<a href="#">Central Illinois:</a> Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, and Stark	PIHP	Molina Health Alliance

**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.**

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

**Mandatory enrollment**

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

- Only those blind or disabled adults who are:
  - Age 21 or older at the time of enrollment;
  - Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D;
  - Receiving full Medicaid benefits;
  - Eligible for and receiving long-term services based on assessed need for nursing facility level of care including:
    - Nursing Facility residents; or
    - Individuals participating in the following 1915 (c) waivers: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities.

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

- Only those aged and related populations are part of this waiver who are:

- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D;
- Receiving full Medicaid benefits;
- Eligible for and receiving long-term services based on assessed need for nursing facility level of care including:
  - Nursing Facility residents; or
  - Individuals participating in the following 1915 (c) waivers: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities.

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

- \_\_\_ Mandatory enrollment
- \_\_\_ Voluntary enrollment

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

- \_\_\_ Mandatory enrollment
- \_\_\_ Voluntary enrollment

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

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

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.

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

- Those who have high third party liability will be excluded from the waiver.

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 ICF/MR facilities are excluded from participation in the waiver. Individuals residing in Nursing Facilities are included in the waiver.

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

- Those enrolled in the MMAI or who choose to enroll in a CCE are excluded from the waiver.

     **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).

- Individuals enrolled in the Adults with Developmental Disabilities HCBS waiver are **excluded** from participation in the waiver. Individuals in the following HCBS waivers are **included** in this waiver: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities.

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

- American Indian/Alaskan Native beneficiaries that meet the waiver criteria are not excluded from participation in the waiver, but may voluntarily enroll in the waiver.

X **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.

**Other** (Please define):

- The State is proposing to exclude:
  - Individuals not in the AABD category of assistance;
  - Individuals under the age of 21;
  - The spend-down population;
  - Individuals enrolled in partial benefit programs;
  - Individuals enrolled in the Illinois Breast and Cervical Cancer Program; and
  - Individuals enrolled in Health Benefits for Workers with Disabilities.

## F. Services

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

- The following Medicaid services are included in the waiver:
  - Long-term Services and Supports provided under Illinois State Plan excluding ICF/MR services and including:
    - Nursing Facility Services
    - All services designed to assist individuals to live independently in the community, such as home health aides, adult day, and environmental adaptations, that are provided under the following IL Home and Community Based Waivers:
      - Persons who are Elderly;
      - Persons with Disabilities;
      - Persons with HIV/AIDS;
      - Persons with Brain Injury; and
      - Supportive Living Facilities Waiver.
  - Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
  - Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090; and
  - Transportation to secure Covered Services.

### 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 assures that the service package provided under the waiver program for eligible waiver enrollees will be in the same amount, duration, and scope as available under the State Plan. Waiver enrollees will have access to all other State Plan services not covered under the waiver program through fee-for-service in the same amount, duration, and scope as required under the State Plan.

- The waiver does not include emergency services or family planning services. Enrollees will continue to receive emergency and family planning services via fee-for-service Medicaid.

\_\_\_ 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.
- The above requirements are not relevant to the waiver. The State assures it will comply with the above requirements outside of the waiver.

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

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

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

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

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

Other (please explain):

Family planning services are not included under the waiver.

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

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:

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

- The waiver does not include FQHC services.

5. **EPSDT Requirements.**

N/A 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.

- The waiver does not include EPSDT services.

6. **1915(b)(3) Services.**

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

7. **Self-referrals.**

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

- Enrollees will be able to self-refer to American Indian Health Services of Chicago for behavioral health services.

## **Section A: Program Description**

### **Part II: Access**

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

#### **A. Timely Access Standards**

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

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

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

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

- The State will comply with these requirements in so far as they are applicable to the waiver.

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

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

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

1. \_\_\_ PCPs (please describe):
2. \_\_\_ Specialists (please describe):
3. \_\_\_ Ancillary providers (please describe):
4. \_\_\_ Dental (please describe):
5. \_\_\_ Hospitals (please describe):
6. \_\_\_ Mental Health (please describe):
7. \_\_\_ Pharmacies (please describe):

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

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

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

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

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

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

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

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

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

7. \_\_\_ Urgent care (please describe):

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

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

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

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

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

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

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

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

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

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

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

## B. Capacity Standards

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

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

\_\_\_\_\_ The State seeks a waiver of a waiver of section 1902(a)(5) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

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

- The State will comply with these requirements in so far as they are applicable to the waiver. For example, the waiver services do not include primary care. 42 CFR 438.207(b)(1) requires PIHPs to submit documentation to the State demonstrating that it offers an appropriate range of preventive and primary care that is adequate for the anticipated number of enrollees for the service area. Therefore, 42 CRF 438.207(b)(1) is not applicable to the waiver.

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

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

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

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

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

Note: above, evaluation of enrollment limits. Limited geographic areas.

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.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. \_\_\_\_ **Other capacity standards** (please describe):

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

## C. Coordination and Continuity of Care Standards

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

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

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

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

- The State will comply with these requirements in so far as they are applicable to the waiver.
- Under the State's continuity of care requirements, PIHPs will be required to offer a 180-day transition period in which enrollees may maintain a current course of treatment with an out-of-network provider. PIHPs may choose to transition enrollees to a network provider earlier than 180 days only if:
  - A health screening and/or a comprehensive assessment, if necessary, is complete;
  - A transition care plan is in place (to be updated and agreed to with the new provider, as necessary); and
  - The enrollee agrees to the transition prior to the expiration of the 180-day transition period.

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

The following items are required.

- a. X 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.

- Based on the limited benefit package PIHPs are responsible for providing to waiver enrollees (primary care and specialist services are not covered services under the waiver) and that PIHPs are required to perform assessments, identify ongoing conditions, and develop treatment plans for all enrollees, the PIHP does not need to meet the requirements under 42 CFR 438.208.
- For all enrollees, PIHPs will be required to follow the process outlined below to identify risk-levels and ongoing special conditions that require care management:
  - Risk Stratification: The PIHP shall use population- and individual-based tools and real-time enrollee data, as available, to identify an enrollee's risk level and any special conditions including:
    - Health Risk Screening. The PIHP will make its best efforts to administer a health risk screening and, if needed, a behavioral health risk assessment to all new enrollees within sixty days after enrollment. The PIHP may administer a health risk assessment in place of the health risk screening provided that it is administered within sixty days after enrollment.
    - Other Information. As feasible, the PIHP may use predictive modeling to proactively identify high-risk enrollees and use other information gathered through avenues such as referrals, service authorizations, alerts, memos, results of the determination of needs assessment (DON) to supplement the health risk screening and/or assessment.
  - Stratification. Based upon an analysis of the information gathered as described above, the PIHP shall stratify all enrollees to the appropriate level of intervention. Enrollees shall be assigned to either low-, moderate-, or high-risk.
  - Health Risk Assessment. The PIHP shall complete a face-to-face health risk assessment within ninety days after enrollment for enrollees stratified as high or moderate risk. For enrollees receiving NF or HCBS services at the time of enrollment, the health risk assessment must be face-to-face and completed within a 180-day transition period.
  - Treatment Plans. The PIHP shall assign a care team, with a care coordinator, to all enrollees. The care team, in conjunction with the enrollee, will develop a comprehensive person-centered treatment plan, unless the enrollee refuses a treatment plan, within ninety days of enrollment. For enrollees residing in Nursing Facilities or receiving HCBS services as of the effective enrollment date, the treatment plan must be developed within 180 days after enrollment.

For individuals deemed newly eligible for HCBS services, the HCBS service plan must be developed within 15 days after the PIHP is notified that the enrollee is determined eligible for HCBS waiver services. For enrollees receiving HCBS waiver services at the time of enrollment, the existing service plan will remain in effect for at least a 180-day transition period unless changed with the input and consent of the Enrollee and only after completion of a face-to-face comprehensive needs assessment in the enrollee's home.

Treatment plans are inclusive of the HCBS service plan. The treatment plan will incorporate any ongoing conditions identified during the stratification process as well as an enrollee's medical, behavioral health, LTSS, social, and functional needs (including those functional needs identified on the DON or other assessment tool that is adopted by the State for HCBS waiver enrollees). It will also include identifiable short- and long-term treatment and service goals to address the enrollee's needs and preferences and to facilitate monitoring of the enrollee's progress and evolving service needs. PIHPs will be required to coordinate and provide referrals to ensure that an enrollee's treatment plan is holistic and person-centered.

- 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. \_\_\_ Each enrollee is receives **health education/promotion** information. Please explain.
- d. \_\_\_ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. \_\_\_ There is appropriate and confidential **exchange of information** among providers.
- f. \_\_\_ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. \_\_\_ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. \_\_\_ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
- i. \_\_\_ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

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

## Section A: Program Description

### Part III: Quality

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

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on 4/11/13.

- The current States MCO quality strategy was submitted to the CMS Regional Office on 4/11/13. The State will submit a revised quality strategy that includes the waiver by January 1, 2014.

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

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

MCO				
PIHP	Health Service Advisory Group		1) Validation of Performance Improvement Projects 2) Validation of performance measures 3) A review, conducted within the previous 3-year period to determine the PIHP's compliance with standards established by the state to comply with 438.204	1) Validation of Encounter Data 2) Administration or validation of consumer or provider surveys of quality of care 3) Calculation of performance measure and validation by EQRO 4) Conduct Performance Improvement Projects in addition to those conducted by PIHP and validated by the EQRO 5) Conduct studies on quality 6) Technical Assistance to PIHP at the State's request

2. **Assurances For PAHP program.**

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

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

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

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

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

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

1. \_\_\_ Provide education and informal mailings to beneficiaries and PCCMs;

2. \_\_\_ Initiate telephone and/or mail inquiries and follow-up;

3. \_\_\_ Request PCCM's response to identified problems;

4. \_\_\_ Refer to program staff for further investigation;

5. \_\_\_ Send warning letters to PCCMs;

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

7. \_\_\_ Institute corrective action plans and follow-up;

8. \_\_\_ Change an enrollee's PCCM;

9. \_\_\_ Institute a restriction on the types of enrollees;

10. \_\_\_ Further limit the number of assignments;

- 11. \_\_\_ Ban new assignments;
- 12. \_\_\_ Transfer some or all assignments to different PCCMs;
- 13. \_\_\_ Suspend or terminate PCCM agreement;
- 14. \_\_\_ Suspend or terminate as Medicaid providers; and
- 15. \_\_\_ Other (explain):

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

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

- 1. \_\_\_ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
- 2. \_\_\_ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
- 3. \_\_\_ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
  - A. \_\_\_ Initial credentialing
  - B. \_\_\_ Performance measures, including those obtained through the following (check all that apply):
    - \_\_\_ The utilization management system.
    - \_\_\_ The complaint and appeals system.
    - \_\_\_ Enrollee surveys.
    - \_\_\_ Other (Please describe).
- 4. \_\_\_ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. \_\_\_ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
  6. \_\_\_ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
  7. \_\_\_ Other (please describe).
- d. \_\_\_ **Other quality standards** (please describe):

4. **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:

## 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

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

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

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.

- The State permits a blind mass mailing – PIHPs do not receive addresses. PIHPs may also use media to mass market including radio, television, or billboards.
3. \_\_\_ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

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

1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.
- PIHPs may not provide gifts or incentives to potential enrollees unless such gifts or incentives are also provided to the general public and do not exceed ten dollars in value per individual gift or incentive.
  - PIHPs must submit all gifts provided to potential enrollees as part of its marketing plan for prior approval by the State.
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 State requires PIHPs to translate marketing materials into Spanish because at least 5 percent of the waiver population speaks this language according to published Census data.

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

- i. \_\_\_ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. X The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.
- iii. \_\_\_ Other (please explain):

## B. Information to Potential Enrollees and Enrollees

### 1. Assurances.

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

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

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

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

### 2. Details.

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

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

The State 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 5 percent or more of the potential enrollee/ enrollee population.
3.  Other (please explain):

- **Spanish**

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

- PIHPs shall operate a language line that makes oral interpretation services available free of charge in all languages to all potential enrollees or enrollees who need oral translation assistance. PIHPs must include in all key oral contacts and written materials notification that such oral interpretation services are available and how to obtain such services. PIHPs shall conduct oral contacts with potential enrollees or enrollees in a language the potential enrollees and enrollees understand.
- In addition, PIHPs will be required to hire staff from in and around the service area to ensure cultural competence. All PIHP staff will receive training on all PIHP policies and procedures during new hire orientation and ongoing job-specific training to ensure effective communication with the diverse enrollee population, including translation assistance, assistance to the hearing impaired and those with limited English proficiency. PIHPs will conduct targeted enrollee focus groups to obtain additional input on PIHP materials and program information, and shall also seek input from local organizations that serve enrollees.

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

- The Client Enrollment Services (CES) will provide counseling to potential enrollees and enrollees to help them understand the managed care program and their managed care options.
- The Department on Aging received approval on its application for the Funding Opportunity for States that would provide financial assistance to SHIPs and/or ADRCs to provide options counseling to dual eligible beneficiaries including those that opt-out of MMAI. This funding will be used to provide information and counseling to potential waiver enrollees on how and when the waiver and MMAI will be implemented, the options dual eligible beneficiaries have for receiving their Medicare and Medicaid services, their appeals rights, and what beneficiaries need to do to participate in the program.

**b. Potential Enrollee Information**

Information is distributed to potential enrollees by:

- \_\_\_ State
- X contractor (please specify) Client Enrollment Services (CES)
  - CES is the State’s enrollment broker.

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

**c. Enrollee Information**

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

- (i)  the State
- (ii)  State contractor (please specify): [The CES will provide required information to potential enrollees.](#)
- (ii)  the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

## C. Enrollment and Disenrollment

### 1. Assurances.

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

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

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

- For potential enrollees and enrollees, the CES sends out mailings including information guides about managed care options and enrollment packets.
- The State will send out provider notices regarding program implementation and program changes.
- The Department on Aging received approval on its application for the Funding Opportunity for States that would provide financial assistance to SHIPs and/or ADRCs to provide options counseling to dual eligible beneficiaries including those that opt-out of MMAI. This funding will be used to provide information and counseling to potential waiver enrollees on how and when the waiver and MMAI will be implemented, the options dual eligible beneficiaries have for receiving their Medicare and Medicaid services,

their appeals rights, and what beneficiaries need to do to participate in the program.

**b. Administration of Enrollment Process.**

State staff conducts the enrollment process.

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

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

Broker name: MAXIMUS

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

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

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

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

- Beginning in September 2014, the waiver will be implemented in two service areas simultaneously – the Greater Chicago service area and the Central Illinois service area with an enrollment phase-in.
- Implementation of the waiver will align with implementation of the Medicare Medicaid Alignment Initiative (MMAI). Beginning in February 2014, the State will begin accepting voluntary enrollments into MMAI. Beginning September 1, 2014, for those beneficiaries receiving LTSS that do not opt-out of the MMAI, the State plans to implement a passive enrollment process by auto-assigning beneficiaries into MMAI.
- All dual eligible beneficiaries who are eligible for the waiver in the Central Illinois and Greater Chicago service areas that opt out of the MMAI will be required to enroll in a PIHP under the waiver unless they choose to enroll in a

CCE or meet the other eligibility exclusions. The same PIHPs will offer services in both the MMAI and waiver.

\_\_\_ 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.):

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

i. X Potential enrollees will have 60 days/~~month~~(s) to choose a plan.

- At least 60 days prior to their passive enrollment into MMAI, beneficiaries will begin receiving enrollment letters informing the beneficiary of their managed care options including MMAI, CCEs, and the waiver.
- Thirty days prior to passive enrollment into MMAI, beneficiaries who have not voluntarily enrolled in MMAI or a CCE or opted out of the MMAI will receive another letter informing them of the MCO to which they will be auto-assigned if they do not select another managed care option. The letter will inform the waiver eligible beneficiary that if he/she opts out of the MMAI and does not chose another managed care option available to them prior to their auto-assignment date, they will be auto-assigned to a PIHP (the same assignment as under the MMAI) under the waiver.
- Beneficiaries enrolled in a Medicare Advantage plan that does not also operate as a MCO in the MMAI will not be passively enrolled into MMAI. If those beneficiaries do not choose a managed care option within 60 days, they will be auto-assigned to a PIHP available under the waiver.

ii. X Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- Auto assignment is based on continuity of care and considers an enrollee's link to an existing waiver MCO, claims history, current LTSS providers, and

geographic considerations. It follows chronologically the criteria listed below:

- Prior enrollment to a PIHP/PCP;
- Provider with the greatest paid claims history;
- Provider with the most recent paid claim; and
- Geomapping: assigns beneficiary to a provider within 30 miles of a beneficiary's residence if an urban area and within 60 miles of residence if a rural area.

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

- \_\_\_ 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:**

- \_\_\_ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
- i. \_\_\_ Enrollee submits request to State.
  - ii. \_\_\_ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

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

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

X The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 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):

- Causes for disenrollment include:
  - Administrative or data entry error in assigning an enrollee to a PIHP;
  - Enrollee moves out of the PIHP service area;
  - Enrollee is no longer eligible for LTSS as determined by the State; or
  - Enrollees will be able to switch PIHPs if their LTSS provider leaves its PIHP's provider network.

\_\_\_ 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 enrollee moves out of the contracting area.

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

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

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

- Unless the enrollee moves out of the contracting area and the waiver does not operate in the enrollee's new area.

## **D. Enrollee rights.**

### **1. Assurances.**

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

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

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

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

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

## E. Grievance System

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

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

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

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

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

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

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 60 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.

- PIHPs are required to provide assistance to enrollees in filing an internal appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The PIHP must make oral interpretation services available free of charge in all languages to all enrollees who need assistance.

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

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

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

- \_\_\_ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)
  
- \_\_\_ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.
  
- \_\_\_ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: \_\_\_\_\_ (please specify for each type of request for review)
  
- \_\_\_ Has time frames for resolving requests for review. Specify the time period set: \_\_\_\_\_ (please specify for each type of request for review)
  
- \_\_\_ Establishes and maintains an expedited review process for the following reasons:\_\_\_\_\_. Specify the time frame set by the State for this process\_\_\_\_\_
  
- \_\_\_ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.
  
- \_\_\_ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.
  
- \_\_\_ Other (please explain):

## F. Program Integrity

### 1. Assurances.

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

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

The prohibited relationships are:

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

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

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

### 2. Assurances For MCO or PIHP programs

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

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

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

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

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

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

## **I. Summary Chart of Monitoring Activities**

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

Please note:

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

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				X						X		
Consumer Self-Report data				X	X	X	X		X	X	X	X
Data Analysis (non-claims)				X		X			X	X	X	X
Enrollee Hotlines		X	X	X	X	X	X		X	X	X	X
Focused Studies									X			
Geographic mapping								X		X		
Independent Assessment	X		X			X	X		X	X	X	X
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by	X						X	X		X		

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

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
adequacy by State												
Quality Review by State				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)

- No national accreditation for the Medicaid services is contractually required.

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

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

- No national accreditation for the Medicaid services is contractually required.

- c.  Consumer Self-Report data
- CAHPS (please identify which one(s))
  - State-developed survey
  - Disenrollment survey
  - Consumer/beneficiary focus groups

- The State requires the PIHPs to complete an Adult CAHPS survey each year. The survey must be completed by a certified CAHPS vendor. The CAHPS survey reports on consumers experience with access to care, provider communication, shared decision making, along with global ratings of providers and health plans. The EQRO is responsible for analyzing the data collected by the CAHPS survey and report plan specific findings to the State.

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

- PIHPs are required to submit quarterly reports summarizing all appeals filed by enrollees and the responses to and disposition of those matters (including decisions made following an external independent review), for the State to review.

- e.  Enrollee Hotlines operated by State

- The State monitors enrollee issues through the HealthCare and Family Services Health Benefit Hotline, the Department of Human Service Help Line, the Department on Aging's Senior Helpline and State Health Insurance assistance Program hotline. Reports will be generated from the hotlines for monitoring and oversight.

- 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).

- The State has included focused quality of care studies as an optional activity the EQRO can perform if requested by the State in the EQRO contract. The State will work closely with the EQRO to develop the study once the State has determined a focused study is needed.

- g.  Geographic mapping of provider network

- The PIHPs are required to analyze the geographic distribution of the provider network on a quarterly basis. The PIHPs generate geographical distribution tables and maps to plot enrollee and affiliated provider locations by zip code and analyze the information. These reports indicate gaps in the contract area and the

PIHPs are required to develop and implement a recruitment strategy to fill the gaps within five days of identifying gaps.

- h.  Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)
- The State will hire an independent evaluator for our Care Coordination Initiatives, including the MLTSS Waiver.
- i.  Measurement of any disparities by racial or ethnic groups
- PIHP's are required to evaluate and take corrective action of any disparities by racial or ethnic groups determined by their plan. PIHPs are expected to utilize the culturally and Linguistically Appropriate Services (CLAS) national guidelines for cultural considerations. Corrective action is expected to be ongoing but plans are required to provide all information related to cultural considerations and ethnic disparities in their annual report. Corrective action can include partnering with telephone and on-site translation services; notifying members of their right to receive information in their preferred language or format; providing printed information in multiple languages and formats, including audio CD; hiring bilingual employees; and providing continuous culture training to employees.
- j.  Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]
- Prior to contracting, the PIHPs are required to submit network analysis reports to the EQRO for review. The EQRO does a thorough analysis by provider type and summarizes findings. The report is presented to the State and the PIHP to indicate and correct gaps in network prior to go live.
- k.  Ombudsman
- The Illinois Department on Aging maintains the Ombudsman program for Long Term Services and Supports. This program includes the Senior Helpline, which helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and the residents or their families. Another place for help is the State Health Insurance Assistance Program hotline, which gives free health insurance counseling to people with Medicare. HealthCare and Family Services runs the Illinois Health Benefits Hotline, which answers any questions regarding Medicaid benefits.
- l.  On-site review
- The EQRO will complete an on-site evaluation of administrative processes and compliance of the PIHPs for year one and no less than every three years

thereafter. The comprehensive compliance review by the EQRO will determine compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. This review will include, but not be limited to the following specific areas:

- Availability of Services
- Timeliness and access of services
- Continuity and coordination of care
- Care Management Systems
- Other information systems
- Evaluation of Administrative process and compliance
- Validation of performance measures
- Policies and operations
- Grievance and appeal.

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

- The PIHPs will be required to participate in a collaborative performance improvement project chosen by both the State and the PIHPs. The topic will be determined based on where there is a need for improvement. The EQRO will provide technical assistance to ensure the Performance Improvement Project (PIP) is designed, conducted, and reported using sound methodology. The EQRO will also validate the PIP to determine the PIHPs compliance with measurement, implementation of interventions to achieve improvement, evaluate the effectiveness of the interventions, and planning activities for increasing and sustaining improvement over time. PIPs are discussed during monthly conference calls and quarterly onsite meetings with the PIHPs and the results of the PIP are reported to the State annually.

- n.  Performance measures [**Required** for MCO/PIHP]  
    Process  
    Health status/outcomes  
    Access/availability of care  
    Use of services/utilization  
    Health plan stability/financial/cost of care  
    Health plan/provider characteristics  
    Beneficiary characteristics

- The state will utilize performance measures focusing on transition between programs, staffing, network capability and access to services. Other areas of focus include reducing admissions to acute hospitals and long term care as well as lowering the readmission rate, retention of members in the community, and measure of care for members residing in nursing homes including management

of urinary tract infections, bacterial pneumonia and prevalence of hospital acquired pressure ulcers.

- o.  Periodic comparison of number and types of Medicaid providers before and after waiver
- Prior to contracting, the PIHPs are required to submit a network analysis report to the EQRO for review. The EQRO does a thorough analysis by provider type and summarizes findings. The EQRO also reviews each PIHP's network on an ongoing basis to ensure that the PIHPs maintain existing providers, and build and enhance current networks before and after implementation of the waiver.
- p.  Profile utilization by provider caseload (looking for outliers)
- q.  Provider Self-report data
- Survey of providers
  - Focus groups
- The PIHPs are required to conduct a Provider Satisfaction Survey and report the results and any necessary corrective action to the State in the annual report.
- r.  Test 24 hours/7 days a week PCP availability
- Since PCP services are not included in the LTSS contract, the State will not complete this monitoring activity.
- s.  Utilization review (e.g. ER, non-authorized specialist requests)
- The PIHPs monitor and report to the state monthly on behavioral health and other covered services activity. Additionally, the PIHPs provide a very detailed annual report, which includes analysis of LTSS services and behavioral health needs, including a discussion of the PIHPs program to address these areas.
- t.  Other: (please describe)



## Section C: Monitoring Results

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

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

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

This is a renewal request.

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

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

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes

\_\_\_\_ No. Please explain:  
Summary of results:  
Problems identified:  
Corrective action (plan/provider level)  
Program change (system-wide level)

## Section D – Cost-Effectiveness

Note to CMS: As the State is applying for a 5-year waiver; the appendices have been completed for five years (P1 – P5).

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

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

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

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

### Part I: State Completion Section

#### A. Assurances

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

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
  - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:  
Robert Mendonsa
- c. Telephone Number: 312-793-5279
- d. E-mail: Robert.Mendonsa@illinois.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. \_\_\_ Other (please explain):

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

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

- a. \_\_\_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  - 1. \_\_\_ First Year: \$ \_\_\_ per member per month fee
  - 2. \_\_\_ Second Year: \$ \_\_\_ per member per month fee
  - 3. \_\_\_ Third Year: \$ \_\_\_ per member per month fee
  - 4. \_\_\_ Fourth Year: \$ \_\_\_ per member per month fee
- b. \_\_\_ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. \_\_\_ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. \_\_\_ Other reimbursement method/amount. \$ \_\_\_ Please explain the State's rationale for determining this method or amount.

## E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a.  Population in the base year data
1.  Base year data is from the same population as to be included in the waiver.
  2.  Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- The State’s Medicaid Eligibility Groups (MEGs) for the MLTSS Waiver cost effectiveness test are as follows:
    - Nursing Facility: This MEG includes individuals receiving NF services.
    - Aged Waiver: This MEG includes individuals participating in the Persons who are Elderly and Supportive Living Facilities 1915(c) waivers.
    - Disability Waivers: This MEG includes individuals participating in the Persons with Disabilities, Persons with HIV/AIDS, and Persons with Brain Injury 1915(c) waivers.
- 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.
- Enrollment estimates for the MLTSS Waiver covered by this 1915(b) waiver application were projected beginning May 1, 2014. The estimates will be affected by the Medicare-Medicaid Alignment Initiative (MMAI), which will begin February 1, 2014 as a voluntary program for dual beneficiaries who are also eligible for this 1915(b) program. The participation rate for the voluntary MMAI was estimated to be 60% for the long-term care population, and the remaining 40% were estimated to enroll in this mandatory 1915(b) MLTSS Waiver.
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- The enrollment projections assume that about 40% of the eligible baseline members will opt-out of the MMAI and into this MLTSS Waiver. They also assume that the PIHPs are successful in rebalancing the population, moving individuals from the nursing facility MEG into the community waiver MEGs. In addition to the enrollment trends that were applied, the

HCBS waiver populations are increasing over time, while the NF population is decreasing over time to reflect this movement.

- d.  [Required] Explain any other variance in eligible member months from BY to P2: \_\_\_\_\_
- The variance between BY and P2 can be explained by the following components:
    - Base year eligibility is split into MMAI versus the MLTSS Waiver.
    - Eligibility trend growth based on historical experience and long term expectations.
    - Population rebalancing, moving individuals out of nursing facilities and into the community under 1915(c) HCBS waiver programs.
- e.  [Required] List the year(s) being used by the State as a base year: SFY 2012 (July 1, 2011 through June 30, 2012). If multiple years are being used, please explain:
- One single year was used as the base year.
- f.  [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period \_\_\_\_\_.
- SFY
- g.  [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
- The base year data is derived directly from the State's MMIS FFS claims and enrollment data warehouse.

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.  [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.

- All services for which the PIHPs will not be responsible were excluded. Estimated capitation rate payments for the waiver were used as a basis for projection of future costs. The capitation rate estimates were based on historical FFS data for those services, which are covered under this 1915(b) waiver with adjustments for the contract period and managed care environment.

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
EQRO			P1: \$0.72
Client Enrollment Services (CES)			P1: \$0.13
Case-mix change savings – note that the savings is not achieved at the MEG level, but in aggregate as the PIHPs successfully	\$8.83 PMPM in P1, with increasing savings potential		

rebalance the population from the institution to the community. This savings estimates the PMPM difference between the projected costs for a rebalanced case mix compared to a baseline non-rebalanced case mix.	thereafter		
Total	\$8.83 in P1 Appendix D5 should reflect this.		Appendix D5 should reflect this.

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 is allocating the administrative costs of the Managed Care Bureau to the waiver based upon the number of projected waiver enrollees as a percentage of managed care enrollees to the costs of the Managed Care Bureau.

**H. Appendix D3 – Actual Waiver Cost**

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

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

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

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

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

<b>1915(b)(3) Service</b>	<b>Amount Spent in Retrospective Period</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>(Service Example: 1915(b)(3) step-down nursing care services</i>	<i>\$1,751,500 or \$.97 PMPM R1</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1</i>

<i>financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i>		<i>\$2,291,216 or 1.10 PMPM in P2</i>
<b>Total</b>	<b>(PMPM in Appendix D3 Column H x member months should correspond)</b>		<b>(PMPM in Appendix D5 Column W x projected member months should correspond)</b>

- b. X The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- This mandatory program will coincide with the MMAI which will be a voluntary program enrolling the same target population as is covered by this 1915(b) waiver. In the development of the MMAI capitation rates, a risk selection factor was applied to reflect a lower expected morbidity due to the passive enrollment procedure and voluntary nature of the program. The residual dual nursing facility and waiver recipients in the applicable geographic regions will be mandatorily enrolled in the MLTSS waiver. As such, an adverse selection adjustment has been applied in these projection calculations to reflect the higher estimated morbidity. The adjustments were developed using the applicable services included under the capitated program only.
- 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. N/A

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:

- The State will withhold a portion of the capitation rate that PIHPs may earn back by meeting annual quality measure targets. The withhold percentages are as follows and apply to both state plan and 1915(c) waiver services:
  - Year 1: 1%
  - Year 2: 2%
  - Year 3: 3%
  - Year 4: 3%
  - Year 5: 3%

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

i. Document the criteria for awarding the incentive payments.

- The state will award incentive payments based on PIHPs meeting annual quality measure targets.

ii. Document the method for calculating incentives/bonuses,

- The State will attribute a portion of the withhold to each quality measure.

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.

- The State will monitor PMPM spending quarterly to ensure that payments to PIHPs including any incentive payments do not exceed the capitation rates.

2. \_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM

providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)

- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

### **Current Initial Waiver Adjustments in the preprint**

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

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

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

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

1. 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: \_\_\_\_\_. Please document how that trend was calculated:

- The actual trend from the base year to the current time period was not available. As such, we have developed long-term trend rates to move the data to the waiver period. Historical data incurred between July 1, 2009 and June 30, 2012 were used to project these trends and were stratified by major category of service (nursing facility, transportation, professional services, and HCBS waiver services). The data included claims payment runout through May 2013. The data were first completed to reflect fully incurred monthly amounts, and then normalized to reflect net monthly utilization and payments by the state excluding the impact of any policy and program changes. Separate adjustments were made for all known policy and program changes items. A linear regression was applied to the normalized historical base data separately for utilization and cost per unit measures. Actuarial judgment was used to develop the final trend rates by service category. The selections were informed by the regression results and other relevant information. The resulting long-term annual trends were used in developing capitation rates for the waiver. The capitation rate period was set to be May 1, 2014 through December 31, 2014, with a midpoint of September 1, 2014. The trend rates were applied by service category in the capitation rate development as follows:

- Nursing facility: (1%) utilization; 2% cost
- Transportation: (6.5%) utilization; 8.5% cost
- Professional (behavioral health) services: (1%) utilization; 2% cost
- HCBS waiver services: 1.5% utilization; 0.5% cost

An additional trend adjustment was made to the center of the waiver projection period, which includes four months of calendar year 2015 (beyond the capitation rate period). The following annual trends were applied for an additional three and one-third trend months to reflect that four months in projection year 1 will have a capitation rate midpoint of July 1, 2015:

- State plan services for all MEGs: 3%
- 1915(c) waiver services for all MEGs: 5%

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 SFY 2010 through 2012**. 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.

- Historical data incurred between July 1, 2009 and June 30, 2012 were used to project these trends and were stratified by major category of service (nursing facility, transportation, professional services, and HCBS waiver services). The data included claims payment runout through May 2013. The data were first completed to reflect fully incurred monthly amounts, and then normalized to reflect net monthly utilization and payments by the state excluding the impact of any policy and program changes. Separate adjustments were made for all known policy and program changes items. A linear regression was applied to the normalized historical base data separately for utilization and cost per unit measures. Actuarial judgment was used to develop the final trend rates by service category. The selections were informed by the regression results and other relevant information. The 34-month inflation trend adjustment factors are included on the tab Appendix D5 in column K for state plan services and column AD for 1915(c) service. The resulting annual aggregate population trends are as follows:
  - Nursing facility MEG PMPM trend:  
 BY to September 1, 2014 trend: 1% state plan services; 2% 1915(c)  
 Prospective trends beyond September 1, 2014: 3% SPS; 5% 1915(c)
  - Aged waiver MEG PMPM trend:  
 BY to September 1, 2014 trend: 1.3% state plan services; 2% 1915(c)  
 Prospective trends beyond September 1, 2014: 3% SPS; 5% 1915(c)
  - Disability waivers MEG PMPM trend:  
 BY to September 1, 2014 trend: 1.3% state plan services; 2% 1915(c)  
 Prospective trends beyond September 1, 2014: 3% SPS; 5% 1915(c)
- ii.\_\_\_\_ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used\_\_\_\_\_. Please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
- 3.\_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented

how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

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

b. 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. X An adjustment was necessary. The adjustment(s) is(are) listed and described below:
    - i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
      - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
      - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
      - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
      - D. \_\_\_ **Determine adjustment for Medicare Part D dual eligibles.**
      - E. \_\_\_ Other (please describe):

- ii.  The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii.  Changes brought about by legal action (please describe):  
For each change, please report the following:
  - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D.  Other (please describe):
- iv.  Changes in legislation (please describe):  
For each change, please report the following:
  - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D.  Other (please describe):
- v.  Other (please describe):
  - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - E.  Other (please describe):

- Known policy and program changes were quantified and applied to develop the projections between the base year (BY) and the first projection year (P1). The adjustments are applied in the Appendix D cost-effectiveness workbook in tab D5, column M for State Plan Services and column AF for 1915(c) Waiver Services. These adjustments were calculated exclusive of the inflation trend component described above to ensure that the effects of these changes were not double-counted. The following changes were made as a result of Illinois legislative changes and other known fee changes or adjustments necessary between the base year and the projection years:
  - Elimination of nursing home bed holds:
    - (2.2%) NF service category PMPM adjustment for Greater Chicago;

- (3.2%) NF service category PMPM adjustment for Central Illinois;
  - (2.3%) overall NF MEG PMPM impact;
  - 0% overall Aged waiver & Disability waivers MEG impact.
  - This estimate is based on a newly approved SPA and the adjustment is included in the total state plan service program adjustment.
- Nursing facility reimbursement structure reform and other fee schedule changes occurring after the base period data:
  - 3.3% cost adjustment for Greater Chicago;
  - 3.3% cost adjustment for Central Illinois;
  - 3.3% overall NF MEG PMPM adjustment;
  - 0% overall Aged waiver & Disability waivers MEG impact.
  - The adjustments were calculated net of average monthly patient pay amounts and include both fee changes which occurred after SFY 2012 and the change in reimbursement methodology to RUGS-IV which will become effective prior to the start of the contract and are included in the total state plan service program adjustment. This estimate is based on a SPA targeted for submission prior to 12/31/13.
- County nursing facility supplemental payment rates:
  - 1.8% cost adjustment for Greater Chicago;
  - 4.8% cost adjustment for Central Illinois;
  - 2.2% overall NF MEG PMPM adjustment;
  - 0% overall Aged waiver & Disability waivers MEG impact.
  - The state estimated the total impact of including additional payments for these specific facilities using May 2013 experience. This adjustment is based on a currently approved SPA.
- Pre-authorization of non-emergent transportation for LTC population:
  - (1.5%) transportation PMPM adjustment to non-emergent transportation services for the NF MEG in the Greater Chicago region;
  - 0% overall NF MEG PMPM impact.
  - The full impact of pre-authorization implementation has recently been reflected in experience, resulting in transportation utilization per thousand rates of about 20,000. The data were adjusted to reflect this experience rate for the specified population and region. The adjustment

was included in the total state plan service program adjustment. This adjustment is based on a currently approved SPA.

- SMART Act rate reduction for transportation providers:
  - (2.7%) cost reduction adjustment applied to eligible provider services where the fee schedule was reduced by legislation in the SMART Act.
  - 0% overall NF, Aged, & Disability MEG impact.
  - The adjustment was included in the total state plan service program adjustment. This adjustment was based on a pending SPA.
  
- De-linking Supportive Living Facility rate increase from a new Nursing Home tax:
  - (2.7%) assisted living service category PMPM adjustment for Greater Chicago and Central Illinois.
  - (0.9%) overall Aged MEG PMPM impact.
  - 0% overall NF & Disability MEG impact.
  - The adjustment was included in the total 1915(c) service program adjustment.
  
- Changes to Department of Rehabilitation Services (DORS) claims processing and service maximum changes:
  - (0.1%) impact for the NF MEG PMPM;
  - (1.0%) impact for the Aged MEG PMPM;
  - (21.9%) impact for the Disability MEG PMPM.
  - These adjustments were developed by comparing both the base year and more recent experience of DORS-paid claims which were rejected from MMIS versus accepted into MMIS. Claim payments were stratified by MEG to quantify the different levels of utilization for each group. Additionally, changes were made between the base year experience and the projection period related to 1915(c) waiver provisions for DORS-paid services. The changes have been estimated to reflect expected cost and utilization for DORS-paid services (both accepted and rejected) in the projection periods. An adjustment is included in the total 1915(c) service program adjustment.
  
- Implementation of managed care for covered services: The projection years reflect adjustments made in the capitation rate development which include (in addition to other adjustments noted in this document): blending of multiple years of FFS base data, shifting the experience to a managed care environment, including managed care savings adjustments, managed care plan

administrative loads, and transitional rate cells to facilitate enhanced rebalancing of the long term care population from nursing facilities into the community.

- 2.8% impact for the NF MEG PMPM;
- 8.8% impact for the Aged MEG PMPM;
- 1.9% impact for the Disability MEG PMPM.
- The impacts illustrated above are as a percentage of the total state plan service and 1915(c) waiver service PMPMs combined for each MEG.

- A section was added to the Appendix D5 tab to reflect 1915(c) waiver base data costs and projection development for those services, which will be covered by the MLTSS 1915(b) program.
- Columns Q and AJ were added to the Appendix D5 tab to reflect the capitation rate withhold incentive payment calculation as described in section D.H.d.1.

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

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

2. 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 cost allocation plan amendment will be filed prescribing a methodology to allocate a portion of the costs of the HFS Managed Care Bureau to the waiver program. A 5.7% administrative trend, developed based on a review of SFY 2010 – 2012 administration costs, was used to project administration costs for P1 – P5.**

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

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

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

ii. \_\_\_ FFS cost increases were accounted for.

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

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1. \_\_\_ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
  - 2. \_\_\_ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e.,*

*trending from present into the future*), the State must use the State's trend for State Plan Services.

i. State Plan Service trend

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

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

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

- Nursing facility MEG state plan service PMPM trend:  
BY to P1 annual trend: 1%  
All future projection years: 3%
- Aged waiver MEG PMPM trend:  
BY to P1 annual trend: 1.3%  
All future projection years: 3%
- Disability waiver MEG PMPM trend:  
BY to P1 annual trend: 1.3%  
All future projection years: 3%

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

- Nursing facility MEG incentive PMPM trend:
  - BY to P1: 0%
  - P1 to P2: 106.0%
  - P2 to P3: 54.5%
  - P3 to P4: 3.0%
  - P4 to P5: 3.0%
- Aged waiver MEG incentive PMPM trend:
  - BY to P1: 0%
  - P1 to P2: 109.9%
  - P2 to P3: 57.3%
  - P3 to P4: 4.8%
  - P4 to P5: 4.8%
- Disability waiver MEG incentive PMPM trend:
  - BY to P1: 0%
  - P1 to P2: 109.9%
  - P2 to P3: 57.3%
  - P3 to P4: 4.8%
  - P4 to P5: 4.8%

3. Explain any differences:

- The trend reflected for the incentive is leveraged by the total capitation rate trend as well as the increase in withhold percentage for the first three years of the program, as the withhold increases from 1% to the ultimate 3% level. The actual inflation portion of the trend is equal to the average annual trend in state plan services plus 1915(c) service in the projection.

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. **N/A**

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

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

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

*Method:*

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

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

1. \_\_\_ Payments outside of the MMIS were made. Those payments include (please describe):

2. \_\_\_ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. X The State had no recoupments/payments outside of the MMIS for the population eligible to participate in this program.

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. **N/A – Individuals receiving nursing facility or HCBS waiver services do not have copays.**

*Basis and Method:*

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

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

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

*Method:*

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

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

*Basis and method:*

1. X No adjustment was necessary
2. \_\_\_ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. \_\_\_ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4. \_\_\_ The State made this adjustment:\*
- i. \_\_\_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
  - ii. \_\_\_ Other (please describe):

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

*Basis and Method:*

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

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

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely

to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. \_\_\_ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2. \_\_\_ **X** This adjustment was made:

a. \_\_\_ Potential Selection bias was measured in the following manner:

- This mandatory program will coincide with the MMAI which will be a voluntary program enrolling the same target population as is covered by this 1915(b) waiver. In the development of the MMAI capitation rates, a risk selection factor was applied to reflect a lower expected morbidity due to the passive enrollment procedure and voluntary nature of the program. The residual dual nursing facility and waiver recipients in the applicable geographic regions will be mandatorily enrolled in this MLTSS 1915(b) waiver program. As such, an adverse selection adjustment has been applied in these projection calculations to reflect the higher estimated morbidity. The adjustments were developed using the applicable services included under the capitated program only. The factors utilized in the corresponding projections were: 1.04 for nursing facility residents; 1.17 for the aging waiver MEG; 1.06 for the other waivers MEG.

b. **X** The base year costs were adjusted in the following manner:

- The base year costs were not adjusted directly. A column was added to illustrate the adverse selection factor adjustment being applied to P1.

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. **N/A**

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

2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3. \_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*

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

### **Special Note section:**

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

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial

period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

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

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

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

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate

value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

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

1. \_\_\_  Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
    - The base year data were adjusted to reflect incomplete data adjustments. Claims and eligibility data with incurred dates of July 1, 2011 through June 30, 2012 were used to develop the base year PMPM costs. The claims experience was paid through May 2013. The development method was used to calculate completion factors by service category. The 1915(c) waiver services required the largest adjustment. The following lists the impact of completion by MEG:
      - 0.6% for the NF MEG
      - 1.4% for the Aged MEG
      - 1.4% for the Disability MEG
  2. \_\_\_ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
  3. \_\_\_ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. \_\_\_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  2. \_\_\_ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes. **N/A**
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
  1. \_\_\_ No adjustment was made.
  2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

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

**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.

- Enrollment estimates for the MLTSS Waiver were projected beginning May 1, 2014. The estimates will be affected by the Medicare-Medicaid Alignment Initiative (MMAI), which will begin February 1, 2014 as a voluntary program for dual beneficiaries who are also eligible for this MLTSS Waiver. The participation rate for the voluntary MMAI was estimated to be 60% for the long-term care population, and the remaining 40% were estimated to enroll in this mandatory 1915(b) MLTSS Waiver.
- The enrollment projections assume that about 40% of the eligible baseline members will opt-out of the MMAI and into this MLTSS Waiver. They also assume that the PIHPs are successful in rebalancing the population, moving individuals from the nursing facility MEG into the community waiver MEGs. In addition to the enrollment trends that were applied, the HCBS waiver populations are increasing over time, while the NF population is decreasing over time to reflect this movement.
- The variance between BY and P2 can be explained by the following components:
  - Base year eligibility is split into MMAI versus the MLTSS Waiver.

- Eligibility trend growth based on historical experience and long term expectations.
- Population rebalancing, moving individuals out of nursing facilities and into the community under 1915(c) HCBS waiver programs.

**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**:
  - The enrollment projections assume that about 40% of the eligible baseline members will opt-out of the MMAI and into this MLTSS Waiver. They also assume that the PIHPs are successful in rebalancing the population, moving individuals from the nursing facility MEG into the community waiver MEGs. In addition to the enrollment trends that were applied, the HCBS waiver populations are increasing over time, while the NF population is decreasing over time to reflect this movement.
  - The variance between BY and P2 can be explained by the following components:
    - Base year eligibility is split into MMAI versus the MLTSS Waiver.
    - Eligibility trend growth based on historical experience and long term expectations.
    - Population rebalancing, moving individuals out of nursing facilities and into the community under 1915(c) HCBS waiver programs.
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**:
  - A linear regression was applied to the historical base data. The data were first normalized for known policy and program changes in order to exclude those changes from the trend analysis. Actuarial judgment was used to develop the final trend rates, and the selections were informed by the regression results and other relevant information.
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**:

- This mandatory program will coincide with the MMAI which will be a voluntary program enrolling the same target population as is covered by this 1915(b) waiver. In the development of the MMAI capitation rates, a risk selection factor was applied to reflect a lower expected morbidity due to the passive enrollment procedure and voluntary nature of the program. The residual dual nursing facility and waiver recipients in the applicable geographic regions will be mandatorily enrolled in this MLTSS Waiver. As such, an adverse selection adjustment has been applied in these projection calculations to reflect the higher estimated morbidity. The adjustments were developed using the applicable services included under the capitated program only. The factors utilized in the corresponding projections were: 1.04 for nursing facility residents; 1.17 for the aging waiver MEG; 1.06 for the other waivers MEG.

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

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

- Please see attached Excel spreadsheets.

**Illinois 1915(b)(4) Waiver Special Terms and Conditions**  
**Waiver Control # IL-01**  
**June 1, 2014-May 31, 2019**

The following are Special Terms and Conditions (STCs) for Illinois' 1915(b)(4) Managed Long Term Services and Supports (MLTSS) Waiver. Compliance with these STCs by the state will enable CMS to monitor the state's progress and performance with this waiver. These STCs relate only to the waiver participants affected by Illinois' 1915(b)(4) MLTSS waiver and are effective from June 1, 2014 through May 31, 2019.

1. The State will comply with the following MLTSS guidance issued May 21, 2013 by CMS.
  - a. **Stakeholder Engagement. The state must continue stakeholder engagement regarding their MLTSS program.** - CMS will expect the State to have a formal process for the ongoing education of stakeholders prior to, during and after implementation that includes managed care plans, providers, beneficiaries, and other key stake holders must also participate in the process. **(As described in section 6 of the 1915(c) waiver application).**
  - b. **Enhanced Provision of Home and Community Based Services-**The MLTSS program must comply with requirements set forth in 42 CFR 441.301(c)(4).
  - c. **Alignment of Payment Structure and Goals-**The State must submit the managed care rates 60 days prior to the implementation of the program and the rates must comply with 42 CFR 438.6. Rates should also be designed to promote services in the community instead of an institutional setting. **(As described in Appendix I & J of the 1915(c) waiver application & Section D of the 1915(b) waiver application).**
  - d. **Support for Beneficiaries-**MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, on-going, and consumer friendly **(As described in Appendix E of the 1915 (c) waiver).**
  - e. **Person-centered Process-**The MLTSS program must require and monitor the implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols. The State has started a process with our sister state agencies to review current practice in relationship to person-centered process and will be including this in our 5 year plan for compliance with the new rules **(As described in Appendix E of the 1915 (c) waiver).**
  - f. **Qualified Providers-** The State must ensure that PIHPs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the PIHP contract. The state will require the managed care plans to contract with existing LTSS providers as PIHP network providers to the extent applicable. The State and PIHP's must provide support to traditional LTSS providers, which may include areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS **(As described in Appendix A of the 1915(c) waiver application).**
  - g. **Participant Protections-**The State must establish safeguards to ensure that participant health and welfare is assured within the MLTSS program, including a

statement of participant rights and responsibilities; a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and fair hearing protections including the continuation of services during an appeal (**As described in Appendices F & G of the 1915(c) waiver application and Section B of the 1915(b) waiver application**).

- h. **Quality**-The State is expected to update its existing managed care quality strategy as required under 42 CFR 438 Subpart D to include the needs of the MLTSS population. The design and implementation of a quality improvement strategy must be transparent. (**As described in Appendix A in the 1915(c) waiver application**).

**2. Independent Consumer Supports.** To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall maintain a permanent system of independent consumer supports (ombudsman) to assist enrollees in understanding the coverage model and in resolving problems regarding services, coverage, access and rights and to inform system evaluation and modification. The State's ombudsman will be fully implemented and will fulfill the requirements described below no later than October 1, 2014.

a. Core Elements of the Independent Consumer Support System.

- i. *Organizational Structure.* The Independent Consumer Supports System shall be autonomous to any IL MLTSS PIHP and the State Medicaid agency. If the Independent Consumer Supports system operates within a sister state agency, the State shall establish firewalls and protections such that no undue influence will be imposed that restricts the ability of the system to perform all of the core functions. In addition, the State will be required to develop a robust system of data collection and reporting, and make available to the public aggregate data that describes system performance and beneficiary issues regarding coverage, services, access, and rights.
- ii. *Accessibility.* The services of the Independent Consumer Supports System are available to all Medicaid beneficiaries enrolled in MLTSS, with priority given to those receiving long-term services and supports (institutional, residential and community based). The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, internet, office) and must use various means (mail, phone, in person), as appropriate, to reach out to beneficiaries and/or authorized representatives.
- iii. *Functions.* The Independent Consumer Supports system assists beneficiaries to navigate and access covered health care services and supports and informs/supports system evaluation and modification. Where an individual is enrolling in a delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The

following list encompasses the system's minimum scope of activity.

- 1) The system shall serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters when the beneficiary isn't able to resolve their concern directly with a provider or health plan.
- 2) The system shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them in navigating those systems and/or accessing community legal resources if needed/requested.
- 3) The system shall include protocols for referring serious and unresolvable issues to higher level state officials and others as necessary in order to ensure the safety and well-being of beneficiaries.
- 4) The system shall develop and implement a program of training and outreach with MLTSS PIHPs, providers, and community based organizations to facilitate cross-organizational collaboration, understanding, and the development of system capacity to support beneficiaries in obtaining covered plan benefits. The state shall track all such activities and include it in reports to state officials and CMS.
- 5) The system shall assist consumers to understand and resolve billing issues, or notices of non-coverage.
- 6) The system shall provide enrollees with information about the processes available to seek remedies when they feel their rights have been violated.

- iv. *Staffing and training.* The Independent Consumer Supports system must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; the health and support needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs, and the community based systems that support them. In addition, the Independent Consumer Supports System shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency. The state shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Independent Consumer Supports system and shall report compliance with this standard in regular reports to CMS. The system shall be staffed sufficiently to address all requests for support consistent with this access standard.
- v. *Data Collection and Reporting.* The Independent Consumer Supports System shall include a robust system of data collection and reporting. The state shall include this data in all quarterly reports to CMS, and shall develop a mechanism for public reporting. **The state will share with CMS copies of all Ombudsman reports submitted to the state legislature within 2 weeks of submission to the legislature. At a minimum, the state shall collect and report, in aggregate, on the following elements:**
  - i. **The date of the incoming request as well as the date of any change in status.**
  - ii. **The volume and type (email, phone, verbal, etc.) of incoming request for assistance.**
  - iii. **The issue(s) presented in incoming requests for assistance.**
  - iv. **The health plan (s) involved in the request for assistance, if any.**
  - v. **The geographic area where the beneficiary involved resides, if applicable.**
  - vi. **The actions taken and individuals/organizations contacted in attempting to address the request.**
  - vii. **The current status of the request for assistance.**
  - viii. **Data providing evidence of compliance with the Independent Consumer Support access standard**
  - ix. The number and type of education and outreach events conducted by the Independent Consumer Supports office.
- vi. *System Enhancement.* The Independent Consumer Supports system shall generate periodic public reports, no less than annually, that describe the functioning of the Independent Consumer Supports system and any enhancements to the program that the state intends to make. The report

shall be issued and submitted to CMS within six months of the end of the calendar year.

- a. The state shall assure that waiver participants are afforded protections such as Ombudsmen services, an appeal process, and a support system to assist participants with information regarding the waiver program.
- b. The state shall assure that waiver participants are educated on the above mentioned services.

**3. MLTSS Implementation.** The state will not implement the MLTSS program any earlier than September 1, 2014.

- a. The state must advise CMS in advance if there are any changes to the implementation date.
- b. The state must provide CMS with an implementation plan by June 30, 2014. The implementation plan must include the following:**
  - i. Identification of any barriers to the September 1<sup>st</sup> implementation date**
  - ii. Identification of any risks associated with implementation and the mitigation strategy associated with those risks**
  - iii. Fail-safe methods in the event mitigation strategies are unsuccessful.**