HealthChoice Illinois

Children with Special Needs

(Waiver #IL-02.R00.00)

1915(b) Waiver Renewal Request
(#IL-02.R01.00)

Original Renewal Submitted December 31, 2020 -
Withdrawn January 26, 2021

Renewal Resubmitted July 2, 2021

Renewal Revised Resubmission June 15, 2022

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

Facesheet

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

The **State** of 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 HealthChoice Illinois - Children with Special Needs (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

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

__ amendment request for existing waiver, which modifies Section/Part _

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

__ Document is replaced in full, with changes highlighted

X renewal request

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

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

Section A is ___ replaced in full

X carried over from previous waiver period. The State:

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

X assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages. (Changes to the original waiver are highlighted in yellow)

Section B is ___ replaced in full

X carried over from previous waiver period. The State:

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

X assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages (Changes to the original waiver are highlighted in yellow)

Effective Dates: This waiver renewal is requested for a period of 2 years; effective July 1, 2022 and ending June 30, 2024 (note that this two-year renewal period is a result of several temporary extensions; the initial renewal submission dated December 31, 2020 requested a two-year period of April 1, 2021 through March 31, 2023). (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is __Mary Doran_____ and can be reached by telephone at (217)_782-3953, or fax at (___)_____, or e-mail at mary.doran@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.

On December 10, 2020, the State notified AIHSC that a 1915(b) waiver renewal application would be submitted to the federal Centers for Medicare & Medicaid Services (CMS) to extend the Children with Special Needs 1915(b) Waiver for an additional two years for the period April 1, 2021 through March 31, 2023. No comments were received from AIHSC.

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).

Background – Illinois Managed Care:

The State of Illinois in partnership with federal CMS, funds healthcare services to approximately 25% of the State's population (3.2 million residents).

In 2011, the Illinois Public Aid Code was amended to require at least 50% of full benefit Medicaid beneficiaries participate in a form of risk-based care coordination by January 1, 2015, to achieve service delivery reforms, cost-containment, program integrity enhancements and improve quality measurement.

Illinois began its system reform from traditional fee-for-service to managed care coordination through the implementation of the Integrated Care Program (ICP) on May 1, 2011 in thirty-two (32) of Illinois' 102 counties. The ICP coordinated and integrated healthcare for the most complex and expensive seniors and persons with disabilities. System reform continued in 2014 with implementation of the Family Health Plan-Affordable Care Act program and Medicare Medicaid Alignment Initiative (MMAI) and further expanded in July 2016 with the roll-out of Managed Long Term Services and Supports (MLTSS)

Continued Transformation of Illinois Managed Care:

In January of 2015, the State announced Illinois' Health and Human Services Transformation, a call to action for collaboration and solution-finding to improve population health and experience of care, while reducing costs. The HHS Transformation is grounded in five themes: prevention and public health; paying for value, quality and outcomes; making evidence-based and data driven decisions through data integration and predictive analytics; rebalancing from institutional to community care; and education and self-sufficiency.

Effective managed care coordination for Illinois Medicaid beneficiaries is central to the success of a fully transformed health and human services system. To achieve optimal benefits of care coordination, enhance quality, improve outcomes, integrate

physical and behavioral health, and to best manage costs without compromising quality of care or access to care, Illinois expanded managed care statewide on April 1, 2018 by implementing HealthChoice Illinois.

Illinois has made significant progress transforming its traditional fee-for-service delivery system into risk-based managed care coordination~~: currently~~ in December of 2018, approximately 2.3 million Medicaid beneficiaries (over 70% of enrollment) are enrolled in managed care. As of December 1, 2020, 2.63 million Medicaid beneficiaries were enrolled in managed care and as of March 1, 2022, 2.78 million Medicaid beneficiaries were enrolled in managed care (approximately 80% of all Medicaid beneficiaries).

Request for 1915(b) Waiver Authority:

To achieve the objectives noted above, the Illinois Department of Healthcare and Family Services (HFS) ~~is seeking~~ in December of 2018 requested a 1915(b) waiver to obtain authority to include populations of children with complex health and social service needs, defined as children: determined eligible for supplemental security income (SSI); determined disabled; receiving Title V care coordination services; in the care of the Department of Children and Family Services (DCFS); and formerly in the care of DCFS and receiving Title IV-E assistance. Services included in this waiver are all State Plan covered services, except any specifically carved out of managed care, and if applicable for an enrollee, HCBS 1915(c) waiver services (Disabled waiver #IL.0142; BI waiver #IL.0329; HIV/AIDs waiver #IL.0202), and 1915(i) State Plan services.

Section 1932(a)(2)(A) of the Social Security Act prohibits mandatory enrollment in managed care for certain children with special needs who are under nineteen (19) years of age.

This 1915(b) waiver renewal application is submitted to CMS for continued approval to include these children with special needs populations in Illinois' mandatory Medicaid managed care program. Specifically, individuals under 19 years of age who:

1) are eligible for supplemental security income under title XVI;
2) are described in section 501(a)(1)(D);
3) are described in section 1902(e)(3);
4) are receiving foster care or adoption assistance under part E of title IV; and
5) are in foster care or otherwise in an out–of–home placement.

A. Statutory Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Delivery Systems

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

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

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

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State

agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.

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

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

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

___ the same as stipulated in the state plan

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

f.___ **Other:** (Please provide a brief narrative description of the model.)

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

_X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)

___ **Sole source** procurement

___ **Other** (please describe)

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

1. **Assurances.**

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

__ The State 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):

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

D. Geographic Areas Served by the Waiver

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

_X_ **Statewide** -- all counties, zip codes, or regions of the State
___ **Less than Statewide**

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1, Northwestern Counties: Boone, Bureau, Carroll, DeKalb, Fulton, Henderson, Henry, Jo Daviess, Knox, LaSalle, Lee, Marshall, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, Woodford **Region 2, Central Counties:** Adams, Brown, Calhoun, Cass, Champaign, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Greene, Hancock, Iroquois, Jersey, Livingston, Logan, McDonough, McLean, Macon, Macoupin, Mason, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott, Shelby, Vermilion **Region 3, Southern Counties:** Alexander, Bond, Clay, Clinton, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Madison, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, St. Clair, Union, Wabash, Washington, Wayne, White, Williamson **Region 4:** Cook County **Region 5, Collar Counties:** DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will	MCO	**STATEWIDE:** • Blue Cross Blue Shield of Illinois ~~• Harmony Health Plan~~ ~~• IlliniCare Health Plan~~ • Meridian Health Plan of Illinois • Molina Healthcare of Illinois • Aetna Better Health (acquired IlliniCare January 2020) **COOK COUNTY ONLY** • CountyCare ~~• NextLevel Health Partners~~ (exited June 30, 2020)

E. Populations Included in Waiver

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

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

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

_X_ Mandatory enrollment
___ Voluntary enrollment

___ **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

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **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.

_X_ Mandatory enrollment

___ Voluntary enrollment

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

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

___ **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 with comprehensive/high third-party insurance are excluded

___ **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).

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

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

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

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

• American Indians/Alaskan Natives that meet waiver criteria may voluntarily enroll in the waiver

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

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

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

_X_ **Other** (Please define):

• Medically needy persons with a spend-down; persons presumptively eligible; persons enrolled in partial/limited benefits programs; persons with comprehensive third-party insurance; persons incarcerated in

a county jail; Illinois Department of Corrections facility or federal penal institution; persons forensically committed to a State operated psychiatric hospital.

• In accordance with Illinois Public Act 100-0990, children authorized by HFS to receive in-home shift nursing services required by federal EPSDT provisions and children participating in the 1915(c) HCBS waiver for medically fragile and technology dependent children (CMS waiver # 0278.R05.00).

F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

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

___ The 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:

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

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

___ 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.

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

• MCOs, through the contract with HFS, are required to: (1) prioritize recruiting safety-net providers, such as FQHCs and RHCs as network providers, and (2) to not refuse to contract with a FQHC or RHC that is willing to accept an MCO's rates and contractual requirements and meets MCO's quality standards. Furthermore, MCOs are required to contract with any willing and qualified Community Mental Health Center (CMHC) when the CMHC agrees to the MCO's rate(s) and adheres to MCO quality standards.

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

5. **EPSDT Requirements.**

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

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

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

7. **Self-referrals.**

_X_ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following

circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

• MCOs are required to provide direct access to: a women's health care provider (WHCP) for routine and preventative women's health care covered services when a female enrollee's PCP is not a WHCP; emergency services; post-stabilization services; family planning services; school-based health centers; school dental programs; MCO-contracted local health departments; and civil status admission to a state-operated hospital. Enrollees with special health care needs have direct access to a specialist, as appropriate for their condition and identified needs. The MCO enrollee handbook must specify how and to what extent an enrollee can obtain self-referred services. Behavioral health mobile crisis response and stabilization services shall not require prior authorization for up to thirty days post-crisis.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

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

7.___ Pharmacies (please describe):
8.___ Substance Abuse Treatment Providers (please describe):
9.___ Other providers (please describe):

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

1.___ PCPs (please describe):
2.___ Specialists (please describe):
3.___ Ancillary providers (please describe):
4.___ Dental (please describe):
5.___ Mental Health (please describe):
6.___ Substance Abuse Treatment Providers (please describe):
7.___ Urgent care (please describe):
8.___ Other providers (please describe):

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

1.___ PCPs (please describe):
2.___ Specialists (please describe):
3.___ Ancillary providers (please describe):
4.___ Dental (please describe):
5.___ Mental Health (please describe):
6.___ Substance Abuse Treatment Providers (please describe):
7.___ Other providers (please describe):

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

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			

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

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

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

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

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

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

and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

- As described in the Department's current Quality Strategy, "persons with special health care needs" are defined as individuals who require long-term services and supports; or, are children eligible under the Medicaid Program pursuant to Article III of the Public Aid Code (305 ILCS 5/3-1 *et seq*.), eligible to receive benefits pursuant to Title XVI of the Social Security Act, receive services under the Specialized Care for Children Act (110 ILCS 345/0.01 *et seq*.), are specified in Section 1932 (a)(2)(A) of the Social Security Act. MCOs are required to use population-based and individual-based tools and real-time data to identify the risk level of enrollees, including: a health risk screening that is administered to all new enrollees within sixty to ninety days of enrollment to collect physical, psychological and social health information; predictive modeling that utilizes claims and Care Coordination Claims Database (CCCD) data to risk stratify individuals and identify high-risk conditions requiring immediate care

management; and data from a variety of sources to assess and monitor enrollees. Based on analysis of this information, enrollees are stratified into the appropriate risk level of care management.

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

• MCOs are required to conduct a health risk screening that is administered to all new enrollees within sixty to ninety days of enrollment to collect physical, psychological and social health information. Enrollees determined to require additional assessment, receive a health risk assessment within ninety to one hundred-twenty days of enrollment, and an individualized plan of care (IPoC) is developed. IPoCs must be routinely reviewed and a reassessement conducted when necessary (but no less than annually).

For enrollees who require behavioral health services, the MCO will ensure that each enrollee's needs and strengths are assessed using the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) Assessment.

When an individual enters DCFS custody a comprehensive health evaluation and interim medical case management is provided.

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

1.__ 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._X In accord with any applicable State quality assurance and utilization review standards.

• A comprehensive and person-centered individualized plan of care (IPoC) is developed, within ninety to one hundred-twenty days of enrollment, by an interdisciplinary care team (ICT) which consists of clinical and nonclinical staff and engages the enrollee, enrollee's family and/or caregiver, and others. IPoC development includes the opportunity for input from an enrollee's PCP. For DCFS Youth, the IPoC includes a DCFS service plan developed by the DCFS caseworker, to ensure authorized services are aligned with DCFS permanency goals. IPoCs are routinely reviewed by the MCO. The IPoC process includes identifying and evaluating risks associated with an enrollee's care, and any negotiated risk(s) must be submitted to the MCO medical director for review. Finalization of the IPoC requires signature by the enrollee or authorized representative or guardian, when applicable. For an enrollee participating in an HCBS 1915(c) waiver, the IPoC includes a person-centered service plan

developed in accordance with 42 CFR 441.301(c). For an enrollee receiving 1915(i) services, the IPoC is developed within the first thirty days of enrollment by an interdisciplinary Child and Family Team (CFT). The CFT helps identify the child and family's needs and strengths holistically across domains of physical and behavioral health, social services, and natural supports. The CFT utilizes a consensus-driven, team-based approach to develop the IPoC. The CFT will be facilitated by a community provider (known as a Care Coordination and Support Organization) and the MCO Case Manager will participate as a key member of the CFT.

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

• For enrollees with special health care needs who require an ongoing course of treatment or regular care monitoring, MCOs are contractually required to have a mechanism to provide direct access to specialists, as appropriate, for enrollees' condition and needs. MCOs are also contractually required to arrange specialty care not available from a Network Provider to be provided by a non-Network Provider via a single-case agreement.

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 to 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.
• Furthermore, the State assures compliance with 42 CFR Part 438 Subpart E.

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

_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 ____.
• An Illinois' MCO Quality Strategy was submitted to CMS on 4/11/2013; an updated Quality Strategy was submitted on April 20, 2017, and ~~the current~~ another updated Strategy was submitted on June 29, 2018. The Department's current 2021-2024 Quality Strategy was submitted to CMS on March 10, 2021.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Health Services Advisory Group		• validation of performance	• validation of consumer

	(HSAG)		improvement projects • validation of performance measures • ~~annual review of various MCO standards~~ review of compliance with Medicaid and CHIP managed care regulations • validation of network adequacy ~~validation activities~~	or provider surveys of quality of care

Note: The contracted EQRO also performs the following: readiness reviews, network analyses, evaluation of State's Quality Strategy, technical assistance at 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):

• MCOs were determined through competitive procurement and based on highest overall scores. Proposal submissions were evaluated on completeness, accuracy, veracity and quality of information. The technical proposal section of the Medicaid Managed Care Organization Request for Proposal (RFP) was valued at a total maximum of 500 points; sections and corresponding points were as follows:
1) Overall approach to improving healthcare quality, ensuring access, and controlling cost trends – 100 points
2) Integration of behavioral and physical health – 80 points
3) Information technology – 70 points
4) High-needs children – 50 points
5) Long-term services and supports – 50 points
6) Payment reform and value-based payment – 50 points
7) Care management and utilization management – 40 points

8) Provider requirements – 40 points
9) Operations – 20 points
The oral presentation and financial proposal sections were valued at a maximum of 100 and 300 points, respectively.

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**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

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

2._X_ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.
• With the exception of prohibited marketing activities specified in the contract, marketing by any medium, including mail, mass-media advertising, and community-oriented, and the content of all marketing materials, is allowed subject to HFS prior approval.

3._X_ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.
• With the exception of prohibited marketing activities specified in the MCO contract, marketing by any medium, including mail, mass-media advertising, and community-oriented, and the content of all marketing materials, is allowed subject to HFS prior approval.

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.
• The MCO contract specifies that the MCO shall not, unless HFS provides prior approval, provide gifts or incentives to potential enrollees unless such gifts or incentives are also provided to the general public and do not exceed US $10 in value per individual gift or incentive and no more than a cumulative annual value of US $50.

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.___ 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 has chosen these languages because (check any that apply):

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

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The State defines prevalent non-English languages as:
(check any that apply):
1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/enrollee population.
3._X Other (please explain):
• The MCO contract requires potential enrollee and enrollee materials to be translated, at a minimum, into Spanish, and where

there is a prevalent single-language minority within the low-income households in the relevant Department of Human Services (DHS) local office area (which is when five percent (5%) or more of such households speak a language other than English, as determined by the Department according to published Census Bureau data).

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.
• The MCO and Illinois Client Enrollment Services (CES) contracts require oral interpretation services be made available free of charge in all languages to all potential enrollees and enrollees who need assistance understanding key oral contacts or written materials. The MCOs and CES must include in all key oral contacts and written materials, for potential enrollees and enrollees, notification that such oral interpretation services are available and how to obtain such services.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.
• The CES assists potential enrollees with initial choice counseling/education and enrollment assistance. The CES also assists enrollees with plan changes through choice counseling/education and enrollment assistance. The CES provides a call center, online enrollment portal, and enrollment materials that include information on the managed care program, plan choices, choice periods, extra benefits, and additional information to assist in making a health plan selection. The CES offers oral translation, TTY capabilities, and provides materials/information to enrollees or potential enrollees in other formats (e.g., video, braille, audio, large print) as requested.
Each MCO is required to mail an enrollee an informative handbook within five business days of receiving an enrollee's initial enrollment record.
Furthermore, HFS routinely provides service providers, advisory committees and community groups with information on the managed care programs and how clients can connect with the CES to receive education and enrollment assistance.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X_ State
_X_ contractor (please specify)
•Illinois Client Enrollment Services (CES); contract with Maximus

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

c. Enrollee Information

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

(i) _X_ the State
(ii) _X_ State contractor (please specify):__CES____
(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

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

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

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

• The State's outreach efforts include a variety of Department and inter-agency meetings related to oversight of the Medicaid program; legislative involvement via public hearings that include testimony from providers, advocates and consumers; Medicaid Advisory Committee and subcommittee meetings that are open to the public; Provider Education Notices issued by the Department; the HFS managed care program web site; direct mailings to enrollees; press releases; approved Health Plan client and provider marketing, member call centers; the CES web site and direct enrollment education and assistance from the CES via the client call center. Furthermore, potential enrollees will receive an enrollment packet in the mail from the CES. This enrollment packet will include information on managed care expansion and the managed care program, information on health plan choices, information on how to get more information about each health plan option, how to make a choice, how to change plans, which populations are excluded, timeframes for making a choice, health plan benefits and more.

Additional informational sessions and trainings will be made available to DCFS field staff, providers who currently serve DCFS Youth, community

stakeholders such as foster parents, adoptive parents and birth parents, through local associations, DCFS provider associations and DCFS advisory committees.

b. **Administration of Enrollment Process**

_X_ State staff conducts the enrollment process.
• HFS conducts the enrollment process for DCFS Youth.

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

_X_ 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: _Illinois Client Enrollment Services (Maximus)
Please list the functions that the contractor will perform:
_X_ choice counseling
_X_ enrollment
___ other (please describe):

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

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

_X_ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):
• The program will be implemented statewide with earliest effective enrollment date of April 1, 2019. Statewide enrollment was effective February 1, 2020 for the children with special needs populations, except for youth in the care of the Department of Children and Family Services (DCFS) for whom enrollment was effective September 1, 2020.

___ 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 _30_ days~~/month(s)~~ to choose a plan.
** Please note that in response to the COVID-19 public health emergency, the Department implemented direct auto-assignment enrollment for the period May 2020 through May 2022.

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.

• Enrollees will have a thirty-day enrollment choice period to select an MCO (except as noted above). If an MCO is not actively selected during this enrollment choice period, the enrollee is assigned to an MCO and PCP via an algorithm (described below). Each enrollee has a ninety-day change period after the effective enrollment date to select another MCO. ~~For DCFS Youth, HFS auto-assigns enrollees with the MCO providing the DCFS Youth Specialty Plan; these enrollees have a ninety-day change period.~~

The algorithm makes assignment to eligible MCOs based on the following: current provider-client relationships with a look- back of six months; existing provider-client relationships based on paid claims data with a look-back of six months; the health plan and PCP assignment of the family member that is closest in age; the geographic location of the client and PCP; provider specialty (e.g., a child would not be assigned to a provider that only serves individuals that are 21 or older); special needs of the client, if known; and capacity limits set by the Department, the health plans and providers. In no instance will an enrollment assignment exceed an MCO's capacity as determined by the Department. In addition, the algorithm will favor auto-assignment into managed care entities with the highest quality scores and levels of compliance with operational proficiency criteria as established by the Department. Quality metrics used to determine the rate of auto-assignment shall be measureable for all managed care entities.

_X_ The State **automatically enrolls** beneficiaries

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

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

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

- For DCFS Youth, statewide, HFS auto-assigns enrollees with the MCO providing the DCFS Youth Specialty Plan; these enrollees have a ninety-day change period.

___ 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.

• A beneficiary is re-enrolled when their case status has not changed and the previous MCO is in active status at the time of re-enrollment.

d. **Disenrollment:**

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

i.___ Enrollee submits request to State.

ii._X_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.

• Enrollees may select another MCO during the initial ninety-day enrollment change period and during the sixty-day annual open enrollment period. These enrollees may disenroll at any time, for reasons with cause, and select another MCO. The State must approve for-cause disenrollment requests.

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):

• Good cause reasons for disenrollment include: an enrollee moves out of the contracting area; due to right of conscience MCO does not provide a covered service; poor quality of care; lack of access to covered services or experienced provider(s); MCO not able to provide all related services at same time, resulting in unnecessary risk to the enrollee; disruptive change in LTSS provider; MCO subject to HFS imposed sanction; and enrollee is re-enrolled but misses open enrollment; and beginning in 2019, when an enrollee's primary care provider terminates contract with an MCO and results in disruption to the enrollee.

___ 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:
• When circumstances are such that an enrollee's continued enrollment with an MCO seriously impairs the MCO's ability to furnish covered services to the enrollee or other enrollees.

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

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

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

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

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

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

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

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

b. **Timeframes**

_X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _60_ days (between 20 and 90).

___ The State's timeframe within which an enrollee must file a **grievance** is _n/a_ days. •An enrollee may file a grievance at any time.

c. **Special Needs**

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

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

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

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

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

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

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

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

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

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

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

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

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

_X_ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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	X
Consumer Self-Report data				X	X	X	X	X	X	X	X	X
Data Analysis (non-claims)				X		X				X	X	X
Enrollee Hotlines		X	X	X	X	X	X		X	X	X	X
Focused Studies										X		
Geographic mapping							X	X			X	
Independent Assessment	X		X			X	X		X		X	X
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy Assurance by Plan	X						X	X			X	
Ombudsman		X	X	X	X	X	X		X	X	X	X
On-Site Review			X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects												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
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 Adequacy by State	X						X	X				
Quality Review by State				X		X		X	X			X
HFS Prior Approval		X	X		X							
Quality Calls & Meetings												X

II. Details of Monitoring Activities

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

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

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

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

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

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

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

• The State requires that any MCO serving at least 5,000 seniors, or people with disabilities, or 15,000 beneficiaries in other populations covered by the Medicaid program that have been receiving full-risk capitation for at least one year are considered eligible for accreditations and shall be accredited by the NCQA within two years after the date the health plan was eligible for accreditation. MCOs must achieve and maintain a status of "Excellent," "Commendable," or "Accredited." If an MCO receives "Provisional" status it must complete a re-survey within twelve months after the accreditation determination. Failure to achieve accreditation may result in the termination of contract.

The State requires that if the managed care entity is organized as an HMO, it must obtain and maintain during the contract term a valid certificate of authority as an HMO under 215 ILCS 125/1-1, *et seq*., and provide proof of certificate of authority upon the Department's request. If organized as a MCCN, for so long as

the managed care entity meets the requirements of 89 Ill. Admin. Code Part 143, the entity may be deemed by the Department to be a certified MCCN.

MCOs are required to authorize the NCQA to submit directly to HFS a copy of their final accreditation survey. On an annual basis between accreditation surveys, MCOs must submit a copy of the accreditation summary report to HFS. HFS annually reviews MCOs' accreditation status and posts this status on the HFS care coordination webpage.

c. _X___ Consumer Self-Report data

_X_ CAHPS (please identify which one(s)): ~~Adult and~~ Child

___ State-developed survey

___ Disenrollment survey

___ Consumer/beneficiary focus groups

• ~~Adult and~~ Child 5.0 CAHPS surveys are annually administered by each MCO. The EQRO evaluates the results of the CAHPS survey and report to HFS specific trends, strengths and opportunities for improvement. The EQRO conducts a CAHPS survey on behalf of HFS for the statewide Medicaid program. The EQRO summarizes results and includes in the annual EQR report. Effective no later than CY2022, the EQRO's statewide CAHPS will include the SNC population.

d. _X___ Data Analysis (non-claims)

___ Denials of referral requests

___ Disenrollment requests by enrollee

___ From plan

___ From PCP within plan

_X_ Grievances and appeals data

___ PCP termination rates and reasons

_X_ Other (please describe)

• Non-claims reports routinely (e.g. monthly, quarterly) provided by the MCOs to ~~collected by~~ HFS include: Fraud and Abuse, Community Outreach ~~Events~~, ~~Outreach Summary,~~ Prior Authorization, HEDIS Measures, Executive Summary, Critical Incidents ~~Detail, Critical Incidents Summary~~, Grievance and Appeals ~~Summary~~, Care Management & Disease Management Summary, Utilization Management, Call Center Statistics~~, and Provider Credentialing~~. Provider credentialing is conducted by HFS through its IMPACT system.

e. _X___ Enrollee Hotlines operated by State

• HFS operates a Health Benefit Hotline and the Department of Human Services maintains a general Help Line. HFS also monitors the Client Enrollment Services call center which provides education and enrollment assistance for eligible enrollees into managed care health plans. Client Enrollment Services creates a task for escalated client issues being referred to HFS for review and handling. These tasks are placed in a real time queue that HFS staff access and monitor throughout the day so issues can be addressed and resolved in a timely manner.

A DCFS Advocacy Office is available to DCFS youth and caregivers to address any questions or concerns related to the managed care. Any YouthCare

inquiries from the DCFS Advocacy Office are immediately shared with the YouthCare MCO. Issues are documented by the MCO and shared daily with HFS and DCFS to ensure timely resolution.

f. ___ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. _X___ Geographic mapping of provider network

~~• The contract requires MCOs to analyze the geographic distribution of their provider network and provide the analysis to the Department on a quarterly basis. The analysis includes generating geographic distribution tables and maps to plot enrollee and provider locations by zip code. In the event gaps are identified, MCOs are required to develop and implement a recruitment strategy within five days.~~ MCOs are required to generate geographic distribution tables and maps to plot enrollee and network provider locations by zip code to monitor network adequacy. In addition, since CY2018 the EQRO conducts annual time and distance analyses to evaluate the degree to which MCOs comply with network standards for all provider types outlined in the contract. The results of the time and distance analyses are illustrated by region and county for all MCOs.

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

• The EQRO conducts an independent evaluation of program impact, access and quality; ~~the State's~~ an actuarial firm conducts an independent evaluation of cost-effectiveness.

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

• MCOs are required to engage and utilize an Enrollee Advisory and Community Stakeholder Committee that provides feedback to the Quality Assurance Program (QAP) Committee on the MCO's performance from enrollee and community perspectives. The committee recommends program enhancements based on enrollee and community needs, reviews provider and enrollee satisfaction survey results, evaluates performance levels, evaluates access and provides feedback on issues requested by the QAP Committee, identifies key program issues such as disparities, that may impact community groups, and offers guidance on reviewing enrollee materials and effective approaches for reaching enrollees. The Committee is comprised of enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations.

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

~~• MCOs are required to analyze the geographic distribution of the provider network and provide the results of this analysis to the State on a quarterly basis.~~

~~MCOs must generate geographic distribution tables and maps to plot enrollee and provider locations by zip code~~. When material gaps in the contracting area are identified, the MCO must, within five business days, develop and implement a recruitment strategy to fill the gaps. Identification of network gaps occurs in various ways, including through the EQRO's reviews, time and distance studies, and notification to the Department by various sources (e.g., provider termination of contract with an MCO).

The contract requires the MCO provider network include all necessary provider types, including PCPs, behavioral health providers, OB/GYNs, dental care providers, hospitals, other specialists, and pharmacies, with sufficient capacity to provide timely covered services to enrollees. Also, prior to contracting, as part of readiness review, the EQRO analyzes network adequacy and prepares a report for the Department and MCOs; any identified network deficiencies are documented, monitored and remediated.

MCOs submit to HFS provider network data quarterly for each of their service areas in a standardized format that includes provider types/categories, a protocol to detect incomplete provider data, and a mechanism for identifying any changes in an MCO's provider network. MCOs submit provider data files that include a range of provider types specific to SNC services. Following submission, the EQRO completes a data validation process and produces MCO-specific and comparative network reports to identify the number of provider types within each county and region across the state, and to evaluate network.

k. ____ Ombudsman

l. __X__ On-site review

• The EQRO completes ~~an annual on-site evaluation of administrative processes and compliance of the MCOs~~ a review at least once every three years to determine the extent to which the MCOs are in compliance with federal standards. The comprehensive compliance review by the EQRO includes, but is not limited to, the following areas: ~~The comprehensive compliance review by the EQRO will determine compliance with standards established by the Department for access to care, structure and operations, and quality measurement and improvement. This review includes, but is not limited, to the following specific areas:~~

- Availability of Services
- ~~Timeliness and access of~~ services Assurances of adequate capacity and services
- Coverage and authorization of services
- Provider selection
- Confidentiality
- Sub-contractual relationships and delegation
- Practice guidelines
- Quality assessment and performance improvement program
- Other federal and state requirements, as determined by the state

~~○ Continuity and coordination of care~~

~~○ Care Management Systems~~

○ ~~Other~~ Health information systems

~~o Evaluation of Administrative process and compliance~~
~~o Validation of performance measures~~
~~o Policies and operations~~
o Grievances and appeals system

m. _X___ Performance Improvement projects [**Required** for MCO/PIHP]
_X_ Clinical
_X_ Non-clinical
• MCOs are required to annually design a PIP to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustained over time, and resulting in a favorable effect on health outcome and enrollee satisfaction. The PIP topic and methodology are submitted to HFS for prior approval. The EQRO provides technical assistance to ensure the project's methodology is sound, and validates the PIP to determine compliance with measurement, implementation of interventions, evaluate effectiveness, and plan activities for continuous improvement. PIPs are discussed during monthly conference calls and quarterly meetings. PIP results are annually reported to the State.

n. __X__ Performance measures [**Required** for MCO/PIHP]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics
• The contract requires MCOs to perform and report on performance measures related to access; utilization; appropriateness of care; behavioral health; LTSS; HCBS health, safety, welfare; maternity care; transition between settings; and preventive/screening services. HEDIS® and HEDIS®-like quality measure specifications methodology, as provided by the State, are used. The MCO must obtain an independent validation of its HEDIS® and HEDIS®-like findings by a recognized entity (e.g., NCQA-certified auditor) as approved by the State. In addition, the EQRO performs an independent validation of a sample of MCO's ~~performance measurement findings~~ HEDIS® and/or HEDIS®-like measures. The EQRO also conducts quarterly HCBS waiver reviews, which collect and report on HCBS waiver-specific CMS performance measures.

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

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

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

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

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

• The contract requires MCOs to have a utilization review committee that implements the utilization review plan and process. This system of internal review includes medical, behavioral health, dental, waiver and long-term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review. MCOs' utilization review committees are assessed by the EQRO through the required compliance review every three years. HFS also receives annual information regarding utilization review via the MCOs' annual Quality Assessment/Utilization Review/Peer Review (QA/UR/PR) report.

t. __X__ Other: (please describe)

Network Adequacy by State – see discussion in section (j) above.

Quality Review by State – HFS conducts quarterly business reviews with each MCO to review performance metrics and discuss key policy, program, and operations issues.

HFS Prior Approval – The Contract requires HFS Prior Approval (review and written approval) of various MCO materials, procedures, or actions.

Quality Calls & Meetings - HFS conducts quarterly quality meetings to discuss progress/outcomes, facilitate staff education, promote equity initiatives, and promote quality-related information specific to MCO performance. During these meetings, HFS and MCO staff discuss performance and quality improvement outcomes with a focus on the Quality Strategy goals and objectives. The meetings include representatives from the Managed Care Organization Quality Team, Bureau of Quality Management, Bureau of Managed Care, and other units who have a vested interest in the topic being discussed.

Section C: Monitoring Results

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

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

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

_X_ This is a renewal request.

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

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

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

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

Please replicate the template below for each activity identified in Section B:
Strategy:
Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

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

Strategy: (b) Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: All contracted MCOs achieved NCQA accreditation. Accreditation status is regularly monitored and updated. Accreditation status is publicly reported on the HFS Care Coordination website at: https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2019HFSWebsiteNCQAAccreditationDoc071119.pdf
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (c) Consumer Self-Report data
Conducted as described: ___Yes ___**X**_No - Please describe: The original waiver document referenced Adult and Child CAHPS; since Adult CAHPS is not relevant, it is being removed in the renewal submission.
Summary of Results: HealthChoice Illinois MCOs conduct an annual Child CAHPS survey that is inclusive of the total Medicaid managed care population; however, the results are not stratified by population. The most recent CAHPs for CY2020 did not capture any of the SNC 1915(b) waiver population due to the delayed implementation that occurred in CY2020.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: Effective no later than CY2022, the SNC population will be included in the EQRO's statewide CAHPS.

Strategy: (d) Data Analysis (non-claims)
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: Non-claims reports collected by HFS that provide SNC population specific data elements include: enrollee grievances and appeals; new enrollee health risk screening and assessment; enrollee engagement risk stratification; provider disputes and grievances; and YouthCare enrollee engagement IPOC. These reports were implemented in the first quarter of CY2021 and are still being refined for data integrity.
Non-claims reports collected by HFS that include SNC in the total program population data elements (reports are not broken down into population specific details): Quarterly Business Review MCO Executive Summary; fraud and abuse; community outreach events; outreach summary; prior authorization; call center statistics; and, provider credentialing (by IMPACT).
Problems Identified: Data was not stratified by the SNC waiver population. However, the Department's EQRO analyzed MCO self-reported data for the SNC waiver population for the period February 2020 through October 2020.
Corrective Action (if applicable): N/A
System-Level Program Change: A report for prior authorizations specific to the SNC population will be added in CY2021 – targeting the second quarter for programming and implementation. In the Department's Managed Care Organization Performance Reporting System (MPR), the MCOs began reporting on prior authorization metrics for SNCs as of Q2 2021 (April – June 2021). The metrics are reviewed quarterly as part of the HFS and MCO MPR Quarterly Business Review process.

Strategy: (e) Enrollee Hotlines operated by State

Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: HFS documents enrollee issues and complaints that are reported through the various State hotlines, as well as from other sources, such as the Client Enrollment Broker and calls made directly to HFS. Issues are monitored by designated staff until resolved. Issues identified as time-sensitive and/or critical are promptly elevated and addressed by designated personnel. Additionally, there is a DCFS Advocacy Office that is available to DCFS youth and caregivers to address any questions or concerns related to the managed care transition. The DCFS Advocacy Office is available to youth and caregivers via phone at 800-232-3798 or email at DCFS.HealthPlan@illinois.gov. DCFS documents any issues or complaints and sends any escalations directly to both HFS and YouthCare. There have not been any problems identified with the DCFS Advocacy office.
Problems Identified: While not a problem, to date, the DHS Help Line has not been utilized by enrollees.
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (g) Geographic Mapping of Provider Network
Conducted as described: ____Yes ___X_No - Please describe: Initially, MCOs developed the geo-mapped information and provided to HFS. HFS determined that the information in geo-map format was not beneficial and was difficult to analyze. The method to monitor, validate, and remediate MCOs' networks transitioned to the EQRO's network adequacy validation processes.
Summary of Results: The EQRO conducted a pediatric time and distance analysis that included all MCOs in August 2020, using May 2020 enrollment and provider network data files. The EQRO conducted four time and distance analyses prior to the Youth in Care implementation on 9/1/2020. Any non-compliant findings were addressed through the corrective action process and remediation is documented. At the time of this renewal submission, the EQRO is in the process of completing a time anddistance study that includes the adult & pediatric populations. The study is based on the provider data submitted by all MCOs in February 2022. Any non-compliant findings will be documented and addressed through the corrective action process.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (h) Independent Assessment of Program
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The Independent Assessment is accompanying this SNC 1915(b) Waiver renewal request.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (i) Measurement of any Disparities by Racial or Ethnic Groups
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The MCOs have engaged and utilized their Enrollee Advisory and Community Stakeholder meetings to provide feedback to their QAP Committee. The

committees have improved quality by listening to their providers and enrollees, reviewing performance levels, evaluating access and offering advice on enrollee materials and ways to locate and reach members. HFS is committed to the delivery of equitable access of its programs and services removing disparate impact on its customers, including SNC, by ensuring each population gets what they need to thrive. HFS will work with service providers, vendors, and contractors to institute approaches that prioritize equity and remove conditions and barriers to achieve optimal outcomes for customers. HFS further commits to engaging with customers who will have input in decision-making and opportunities to assist in advancing racial equity. HFS is committed to making equity the foundation of everything it does.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: Beginning in CY2021, HFS is requiring MCOs to report both HEDIS and various outcome measures by specific geographies, race, and gender in order to identify inequity and disparities. The MCOs report HEDIS and custom measures directly to the EQRO; the EQRO provides the performance measure data to HFS. HFS will hold MCOs accountable to develop specific action plans to address the findings for specific populations.

Strategy: (j) Network Adequacy Assurance Submitted by Plan
Conducted as described: __Yes ___**X**_No - Please describe: As discussed above, the MCOs no longer conduct geographic analysis to determine network adequacy; the EQRO assumed this responsibility in CY2019.
Summary of Results: The EQRO conducts an annual time and distance analysis of network providers. MCOs are required to respond to any non-complaint findings through the corrective action process and document remediation to correct deficiencies identified. The EQRO conducted a provider network readiness review that included:

- The location and number of contracted providers by type by county and by region. This analysis identified that there was an adequate provider network available for the SNC waiver population.
- A pediatric time and distance analysis was conducted across all regions for all health plans for 25 provider types to assess compliance with the time and distance standards.
- For the DCFS population the EQRO worked with HFS to identify the high utilization providers who served the DCFS population under FFS. YouthCare was required to contract with all high utilization providers prior to program implementation. This network/contracting review process started in November 2019 and continued until program implementation on September 1, 2020. YouthCare was compliant with contracting with the high utilization providers and the MCO met the provider network capacity requirements prior to program implementation.
- The EQRO conducts a biannual analysis of the location and number of contracted providers by type, by county, and by region. Results have continued to confirm adequate provider network for the SNC waiver population.
- The EQRO completed a provider directory validation study in January 2021 that included the provider data for all MCOs as of August 2020. The study included review of OB-GYN, adult & pediatric primary care providers (PCPs) and dentists. All non-compliant findings were addressed through the corrective action process.

Remediation period was documented and closure of the corrective action process occurred in June 2021.

- The EQRO is in the process of completing an access and availability survey of provider locations to evaluate the average time to an appointment for five specialty provider types. The study is based on the provider data submitted by all MCOs in February 2022. Any non-compliant findings will be documented and addressed through the corrective action process.

Problems Identified: The pediatric time and distance study identified non-compliance with the time and distance standards for four MCOs for selected specialty providers. MCOs are required to submit a written corrective action to remediate the gaps identified. The CAP is monitored by the EQRO.
Corrective Action (if applicable): as discussed above
System-Level Program Change: None

Strategy: (l) On-Site Review
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The EQRO conducted a readiness review prior to program implementation. Any deficiencies were required to be remediated prior to program implementation. In addition, the EQRO conducted a compliance review in 2020 and any deficiencies identified as a result of the 2020 compliance review are required to be remediated by the MCOs.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (m) Performance Improvement Projects
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: For CY2020, the MCOs performance improvement project included the HEDIS measure Follow-Up after Hospitalization for Mental Illness (FUH). The goal of the PIP topic was to increase the rate of 30-day follow-up with a mental health practitioner for members six years of age and older. Results of the FUH PIP demonstrated that all health plans achieved improved performance when compared to baseline. While PIP results were not reported specific to the SNC population, the measurement results could be extrapolated for the SNC Waiver population.
Problems Identified: None, although not specific to the SNC population.
Corrective Action (if applicable): None
System-Level Program Change: During the two-year renewal period, HFS will evaluate the efficacy of a PIP specific to the SNC Waiver population as the program matures and MCOs and HFS have experience and data available for the population to potentially identify an SNC-specific PIP topic. For 2022, HFS requested that the health plans develop a PIP to address timeliness of transportation for the SNC population. HFS will continue to review additional data to identify when additional PIPs are warranted.

Strategy: (n) Performance Measures
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The SNC population were not included in collection and reporting of the 2020 HEDIS measures as the measurement year was CY 2019 for HEDIS 2020 and the SNC

program was not implemented until February 2020. In addition, the SNC population is not large enough to stratify the HEDIS measure results specifically to the SNC population. HFS may opt to extrapolate the results of the Child HEDIS measures to the SNC population. When the MCOs and HFS have history and data specific to the SNC population HFS will consider development of measures specific to this population. In 2021, HFS established performance measures specific to the YouthCare Specialty Plan, including HEDIS and custom measures. Performance measures will be reported in 2022.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: None

Strategy: (o) Periodic Comparison of Number & Types of Medicaid Providers Before/After Waiver
Conducted as described: ____Yes ___X_No - Please describe: This activity was not conducted as there was not a count of Medicaid FFS providers for the entire SNC population.
Summary of Results: However, the EQRO conducted a network readiness review that included a count of Medicaid providers by provider type/county/region by MCO. This review confirmed an adequate network of providers for program implementation. Following program implementation, the network is monitored by the EQRO on a bi-annual basis.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: This quality monitoring activity is being removed as a required activity for the requested SNC 1915(b) Waiver renewal period.

Strategy: (s) Utilization Review
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: All MCOs routinely report on utilization review. The EQRO analyzed MCO self-reported data for the SNC population for the period February 2020 through October 2020 and did not identify any areas of concern related to the MCOs' processes for utilization management of the SNC waiver population. Furthermore, following implementation of YouthCare, HFS staff worked closely with the MCO to monitor utilization review and prior authorization to promptly identify trends and remedy issues.
Problems Identified: None
Corrective Action (if applicable): N/A
System-Level Program Change: In the MPR, the MCOs began reporting on prior authorization metrics for SNCs as of Q2 2021 (April – June 2021). The metrics are reviewed quarterly as part of the HFS and MCO MPR Quarterly Business Review process. All health plans reported findings of their utilization management program for the SNC population in their annual QA/UR/PR reports beginning SFY 2021.

Section D – Cost-Effectiveness

Please note that Section D is replaced in its entirety for this June 15, 2022 renewal submission.

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:
Dan Jenkins

c. Telephone Number: 217-785-0710

d. E-mail: Dan.Jenkins@illinios.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._X_ The State makes enhanced payments to contractors or providers.

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

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

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

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and

- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

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

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

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

a.__X_MCO
b._ _ PIHP
c.___ PAHP
d.___ Other (please explain):

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

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

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

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

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

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

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

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

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

For Conversion or Renewal Waivers:

a._X__ [Required] Population in the base year and R1 and R2 data is the population under the waiver. Due to delays in the implementation of these populations in managed care, the population covered under the waiver did not enter managed care until February 1, 2020 for the SNC and DCFS–Former Youth in Care rate cells and September 1, 2020 for the DCFS–Youth in Care rate cell.

- The State's Medicaid Eligibility Groups (MEGs) for the SNC Waiver cost effectiveness test are as follows:
  - DCFS / SNC, Non-CHIP: This MEG includes all beneficiaries in the Department of Children & Family Services (DCFS) Youth in Care rate cell, DCFS Former Youth in Care rate cell, and Special Needs Children (SNC) rate cell that are eligible through Title XIX. These beneficiaries represent foster children under state guardianship (Youth in Care), children receiving adoption assistance (Former Youth in Care), and children with special healthcare needs (SNC).
  - SNC, CHIP: This MEG includes all beneficiaries in the SNC rate cell that are eligible through Title XXI (i.e. CHIP). There are no beneficiaries in the DCFS rate cells that are eligible through Title XXI.

    Note, approximately 20,000 children enrolled in the SNC population were previously enrolled in managed care within the Disabled Adult and Non-

Disabled Children and Adults populations. These individuals were transferred to the SNC population on February 1, 2020.

In developing the projections in the cost effectiveness workbook, the three rate cells were projected separately, since they are paid different capitation rates. Throughout this narrative summary, we will often describe the assumptions for each rate cell. Unless specifically noted, assumptions are consistent between CHIP and non-CHIP beneficiaries since the capitation rates do not vary based on CHIP eligibility.

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

c._ X _[Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: Enrollment for these MEGs has not been affected materially by the COVID-19 pandemic to the same extent as other HealthChoice Illinois populations. However, there have still been changes in enrollment since the base year. The projected member months represent the most current projections of enrollment for P1 and P2.

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

e._X__[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: The base year is CY 2019. R1 is April 2019 through March 2020, and R2 is April 2020 through March 2021. Five temporary extensions were also granted by CMS, which extended the initial waiver period through June 30, 2022. Due to the delay in implementation of these populations in managed care described above, we have limited managed care data available for R1 and R2 and have not reported this information in the cost-effectiveness analysis.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: Consistent with the initial waiver filing, all Medicaid-covered services are included in the waiver, reflecting both services that will be covered by the managed care plans under the waiver, as well as services that will remain covered on a FFS basis but are impacted by MCOs, such as emergency transportation. This waiver includes 1915(c) waiver services for three waivers

(Disabled waiver #IL.0142, Brain Injury waiver #IL.0329, HIV/AIDS waiver #IL.0202). Costs for these waiver services are covered under the managed care contract and are not paid by HFS on a FFS basis.

This waiver also reflects services included in the 1915(i) SPA with an effective date of July 1, 2022. These services will be included in the MCO capitation rates, and the projections in this waiver renewal include the costs that are projected to be added to the capitation rates for these services. The estimated costs associated with these services are based on projected utilization of each waiver service separately for each rate cell, along with an estimated monthly cost per user. The projections assumed a ramp-up in utilization of services over the first year of implementation. Projected utilization and cost per user are consistent with the most recent 1915(i) SPA submission available as of the date of this renewal submission.

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

- Waiver services provided to developmentally disabled persons and services related to local education agencies are excluded from the cost-effectiveness analysis. These services are paid on a FFS basis and are not considered impacted by the MCOs. All other Medicaid-covered services are included in the waiver, reflecting both services that will be covered by the managed care plans under the waiver, as well as other services that will remain covered on a FFS basis.
    - This includes emergency transportation services, which are covered on a FFS basis by HFS but are considered impacted by the MCOs, due to the interaction with other services provided by the MCOs.
    - Applicable 438.6(c) state-directed payments that are reflected in the capitation rate development as a separate payment are also included in this analysis. The directed payments that are applicable to these populations are the Large Non-State Government Hospital, CCHHS Clinics, Managed Care Access Payments, and Illinois State Hospital Physicians ACR.
    - Both the emergency transportation services and 438.6(c) directed payments are included within the State Plan services columns for purposes of this cost-effectiveness analysis.

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

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

a._X The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.* Based on CMS 64 administrative cost information, administrative expenses were allocated to the DCFS Youth (both Youth in Care and Former Youth in Care) and SNC populations based on the number of waiver enrollees as a percentage of total Medicaid enrollees. Administrative costs were split between the CHIP and non-CHIP MEGs based on aggregate State Plan and waiver service expenditures in the base period. Additionally, administrative costs reported in the CMS 64.10 form were used in the allocation of administrative costs by line item.

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

c.___ Other (Please explain).

G. Appendix D3 – Actual Waiver Cost

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

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

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

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

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

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

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

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

b._X_ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations: Due to the small American Indian/Alaskan Native population eligible for this program, the potential for selection bias that would materially affect the funding for this program is minimal. As of January 2021, there were fewer than 150 American Indian/Alaska Natives eligible for this 1915(b) waiver program, out of roughly 80,000 total individuals.

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

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

2._X _The State provides stop/loss protection (please describe):
MCOs are not required to purchase reinsurance.

d.__X__Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

There are no incentives in the CY2019 base experience period.

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

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

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

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

Current Initial Waiver Adjustments in the preprint

H. 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:
10.0% for the DCFS Youth in Care, 11.3% for DCFS Former Youth in Care, and 15.1% for the SNC population. The composite trend rate for the non-CHIP MEG was 13.1%. As noted earlier, the CHIP MEG is entirely comprised of SNC beneficiaries, so the trend rate was 15.1%.
Please document how that trend was calculated:
Trends from CY 2019 to CY 2022 are consistent with the development of managed care capitation rates effective during CY 2022. Trends were developed by service category and the values in this projection represent the composite trend across all service categories.

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: January 2017 through December 2019. 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.

- Trend rates assumptions from CY 2022 through CY 2024 were based on analysis of FFS experience from January 2017 through December 2019, linear regression, Medicaid benchmark trends, and actuarial judgment. The trends also account for expected return of services deferred during the COVID-19 pandemic. These trend assumptions, from P1 to P2, were 9.0% for the DCFS rate cells and 10.0% for the SNC rate cell. The resulting composite trend assumptions were 10.0% for the CHIP MEG and 9.6% for the non-CHIP MEG.

- Note that P1 represents 6 months of rates from the CY 2022 capitation rate amendment and 6 months of projected CY 2023 rates. P2 is a blend of 6 months of projected CY 2023 rates and 6 months of projected CY 2024 capitation rates.

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

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

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

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

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

Others:

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Determine adjustment for Medicare Part D dual eligibles.
E.____Other (please describe):

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

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

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

v.__ X Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
E.____X Other (please describe):

- Adjustments have been made for programmatic or legislative changes occurring after the end of the base year period (December 31, 2019). Program changes are documented in our certification report for the SNC and DCFS capitation rates. The majority of program changes can be characterized as fee schedule adjustments. Among the fee schedule adjustments was a material fee schedule

increase for Home and Community Based Service providers, which is a key driver of the program changes for the 1915(c) Waiver Service costs.

- For the Youth in Care MEG rate cell, a key program change involves the inclusion of costs related to the HealthWorks program and other services provided by the Illinois Department of Human Services (DHS). These costs are not included in the state administration costs for the base year, as we do not believe FMAP was claimed for these services previously. These CY 2022 costs include $40.76 PMPM for contracting with HealthWorks and $4.92 PMPM for contracting with DHS. Healthworks is an entity providing care management services for these beneficiaries. The primary goals of HealthWorks are to ensure each child is receiving preventive health care services, connected with a primary care provider, and the child's health care plan is incorporated into the child's overall DCFS service plan. DHS provides support for individuals age 6 and under, which is distinct from the services provided by HealthWorks described above. The HealthWorks and DHS payments are only received by Meridian. It is anticipated that Meridian will cover the vast majority of DCFS beneficiaries.
- Additionally, for the SNC MEG, roughly 40% of SNC members had been receiving NDCA or DA capitation rates in the base year. An adjustment was required from the Base Year to P1 because these capitation rates were materially lower than actual expenditures for these individuals. This adjustment, illustrated in the 'Adjustment for Population Transition' column in worksheet D5., was not required from P1 to P2.

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._X No adjustment was necessary and no change is anticipated.

2._ __ An administrative adjustment was made.

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

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

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

C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

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

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

C.____Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____
   - For these MEGs, the withhold is 2.0% of capitation rates in both P1 and P2. The withhold percentages were not applied to services carved-out of the capitation rates.

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a**
   There were no incentive payments in the Base Year. P1 to P2 incentive trend rates reflect the changes in total capitation payment, with the withhold percentage remaining at 2% for each year. For each MEG, the trend on State Plan services was set such that the total trend on non-administrative services from CY 2022 to CY 2023 (inclusive of incentive payments) is equal to the trend rates described above, which are 10.0% for CHIP and 9.6% for non-CHIP.

3. Explain any differences: The incentive costs trends are consistent with State Plan service trends.

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

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

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

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

Method:

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported

and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ 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 populations 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.

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._X__ Other (please describe): DCFS Youth and SNC Population do not have copays under the FFS or managed care delivery system.

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

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

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

Method:

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

2.___ Determine copayment adjustment based on pending SPA.

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

4.___ Other (please describe):

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

Basis and method:

1._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.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3._X_ Other (please describe): Federal and supplemental rebates in CY 2019 are estimated at 50% of gross pharmacy expenditures for the populations included in this waiver. Expenditures for both the base and projection years have been reduced for pharmacy rebates. This assumption is based on historical data. Actual rebate percentages may vary materially based on HFS moving to a single PDL requirement for its managed care populations effective January 1, 2020 and rebate percentages for individual pharmaceutical products.

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

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

1. This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. This adjustment was made:
   a. ___Potential Selection bias was measured in the following manner:

   b.___The base year costs were adjusted in the following manner:

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

1. X We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner: Summarized costs for the base year period only reflect fee-for-service payments for FQHCs/RHCs which are built into the projected capitation rates.
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.__X_The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

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

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

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

1. X 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 CY 2019 incurred dates, paid through May 31, 2021,

were used to develop the base year PMPM costs. The development method was used to calculate completion factors by service category. The following lists the impact of completion by rate cell:

- 0.3% for the DCFS Youth in Care cell
- 0.3% for DCFS Former Youth in Care rate cell
- 0.7% for the SNC rate cell

The following lists the impact of completion by MEG:

- 0.5% for the non-CHIP MEG
  0.5% for the CHIP MEG

- The completion adjustments were not applied to the managed care capitation payments for SNC enrollees in managed care during the base year.

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**.

I. 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: ____ 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._X__ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between 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. Trend rates are consistent with projected capitation rates during P1 and P2. Trend rate development is documented in the capitation rate certification for the SNC and DCFS populations. As stated in the certification, utilization trend rates reflect both changes in the utilization rate and intensity of services.

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

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the

MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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

2._X__An adjustment was necessary and is listed and described below:

i.__ 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.__ X 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.____X Other (please describe): The impact of program adjustments between the Base Year and P1 is documented separately from State Plan and 1915(c) waiver trend assumptions. The actuarial rate

certification for CY 2022 documents various programmatic changes that include additional covered services and modification to provider reimbursement rates.

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**

MEG	Base Year to P1	P1 to P2
CHIP	15.1%	10.0%
Non-CHIP	13.1%	9.6%

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____
There were no incentive payments in the Base Year. P1 to P2 incentive trend rates reflect the changes in the withhold percentage described above. As a result, the implied trend on incentive payments is high for both MEGs. For each MEG, the

trend on State Plan services was set such that the total trend on non-administrative services from CY 2020 to CY 2021 (inclusive of incentive payments) is equal to the trend rates described above, which are 10.0% for CHIP and 9.6% for non-CHIP.

3. Explain any differences: The incentive costs trends are consistent with State Plan service trends.

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

J. 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.

K. Appendix D6 – RO Targets

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

L. 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**:

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. Actuarial judgment was used to develop the final trend rates, and the selections were informed by the regression results and other relevant information. Separate trend rate assumptions for utilization and unit cost were not developed.

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**:

- A linear regression was applied to the historical base data. Actuarial judgment was used to develop the final trend rates, and the selections were informed by the regression results and other relevant information. Separate trend rate assumptions for utilization and unit cost were not developed.

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.