

HealthChoice Illinois
Children with Special Needs

June 29, 2018

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Instructions – see Attachment 1

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective ~~10/1/2018~~ April 1, 2019 and ending ~~9/30/2020~~ March 31, 2021. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is 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.

In Illinois, as of June 30, 2017, there were 6,105 self-designated Native American/Alaskan Natives (AI/ANs), which includes individuals who selected more than one race on their Medicaid application, enrolled in the Medicaid program.

Illinois' formal process to ensure Federally recognized tribes are aware of changes to the State's Medicaid program includes informing the sole Indian Health Services (IHS) provider, American Indian Health Services of Chicago (AIHSC), in writing of the proposed changes, description of expected impact to AI/ANs, and a copy of available, relevant documents. State policy provides AIHSC a minimum two-week comment period.

On April 4, 2018, the State provided the above information to AIHSC regarding this 1915(b) application; no comments were provided by 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:

Currently, 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, Governor Bruce Rauner 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, approximately 2.3 million Medicaid beneficiaries (over 70% of enrollment) are enrolled in managed care.

Request for 1915(b) Waiver Authority:

To achieve the objectives noted above, the Illinois Department of Healthcare and Family Services (HFS) is seeking 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.

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

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

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

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

- a. **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. **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. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

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

- a. **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP**: Prepaid Inpatient Health Plan means an entity that:
 - (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
 - The PIHP is paid on a risk basis.
 - The PIHP is paid on a non-risk basis.
- c. **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)

does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

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

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

the same as stipulated in the state plan

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

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

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

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

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

Sole source procurement

Other (please describe)

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

1. Assurances.

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

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

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

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

3. Rural Exception.

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

4. 1915(b)(4) Selective Contracting

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

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

D. Geographic Areas Served by the Waiver

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

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

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
<p>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</p> <p>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</p> <p>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</p> <p>Region 4: Cook County</p> <p>Region 5, Collar Counties: DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will</p>	<p>MCO</p>	<p>STATEWIDE:</p> <ul style="list-style-type: none"> • Blue Cross Blue Shield of Illinois • Harmony Health Plan • IlliniCare Health Plan • Meridian Health Plan of Illinois • Molina Healthcare of Illinois <p>COOK COUNTY ONLY</p> <ul style="list-style-type: none"> • County of Cook/County Care • NextLevel Health Partners

E. Populations Included in Waiver

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

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

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

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

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
 Voluntary enrollment

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

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

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

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

- 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.

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.

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.

- 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).

- 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.

- 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:

- 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.
- 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.

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.

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.

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

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

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

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

2. 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.

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

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

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

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

2. **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.

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

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

1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. In accord with any applicable State quality assurance and utilization review standards.

- 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.

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

- 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.

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 updated Strategy will be ~~was~~ submitted no later than July 1 on June 29, 2018.

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 (HSAG)		<ul style="list-style-type: none"> validation of performance improvement projects validation of 	<ul style="list-style-type: none"> validation of consumer or provider surveys of quality of

			performance measures • annual review of various MCO standards • network adequacy validation activities	care
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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):

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:

• 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.

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

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

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

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

2. Details

a. **Scope of Marketing**

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.
 - 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. 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. 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.

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The State defines prevalent non-English languages as:
(check any that apply):

1. ___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
2. ___ The languages spoken by approximately ___ percent or more of the potential enrollee/enrollee population.
3. 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).

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.

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:

- State
- 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) the State
- (ii) State contractor (please specify): CES
- (ii) the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

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

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

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

- State staff conducts the enrollment process.
 - HFS conducts the enrollment process for DCFS Youth.
- The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
 - The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Illinois Client Enrollment Services (Maximus)

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

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

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

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

• The program will be implemented statewide with earliest effective enrollment date of ~~October 1, 2018~~ April 1, 2019.

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

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

i. Potential enrollees will have 30 days/~~month(s)~~ to choose a plan.

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

• Enrollees will have a thirty-day enrollment choice period to select an MCO. If an MCO is not actively selected during this enrollment choice period, the enrollee will be 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.

— The State **automatically enrolls** beneficiaries

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

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

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

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

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

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:

The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the

first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. ___ Enrollee submits request to State.

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

• 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.

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.

___ 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.

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

i. 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.

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.

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.

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

E. Grievance System

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

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

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

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

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

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

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

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

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

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

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

b. Timeframes

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

The State’s timeframe within which an enrollee must file a **grievance** is 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 procedure 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.

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.

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 excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

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

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

II. Details of Monitoring Activities

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

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

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

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

NCQA
 JCAHO
 AAAHC
 Other (please describe)

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

NCQA
 JCAHO
 AAAHC
 Other (please describe)

• 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. Consumer Self-Report data
- 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.
- d. Data Analysis (non-claims)
- Denials of referral requests
 - Disenrollment requests by enrollee
 - From plan
 - From PCP within plan
 - Grievances and appeals data
 - PCP termination rates and reasons
 - Other (please describe)
- Non-claims reports 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.
- e. 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.
- f. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
- g. Geographic mapping of provider network

- 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.
- 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 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.
- 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.

k. _____ Ombudsman

l. On-site review

• The EQRO completes an annual on-site evaluation of administrative processes and compliance of the MCOs. 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
- Continuity and coordination of care
- Care Management Systems
- Other information systems
- Evaluation of Administrative process and compliance
- Validation of performance measures
- Policies and operations
- Grievances and appeals

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

Clinical

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. 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.

- o. 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. 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
- t. Other: (please describe)

Section C: Monitoring Results

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

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

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

This is a renewal request.

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

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

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Section D – Cost-Effectiveness

Note, the Appendix D workbook and narrative will be amended to reflect the final capitation rates for the DCFS Youth and Special Needs Children populations.

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

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

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

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

- Do not complete **Appendix D3**

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

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

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

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

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

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

- The State's Medicaid Eligibility Groups (MEGs) for the DCFS / SNF Waiver cost effectiveness test are as follows:
 - DCFS Youth: This MEG includes Department of Children & Family Services Youth beneficiaries. These beneficiaries represent foster children and children receiving adoption assistance.
 - Special Needs Children This MEG include expected managed care enrollees that will covered under the Special Needs Children population. Children through age 20 are eligible to be enrolled in managed care under this population.

Note, approximately 2,000 children that will be enrolled in the Special Needs Children or DCFS Youth population are currently enrolled in managed care within other populations. These individuals are scheduled to transfer to the Special Needs Children (SNC) population on ~~October 1, 2018~~ April 1, 2019.

- 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.
- The base year member months excluded the first three months of FFS Medicaid eligibility for all beneficiaries. This is a proxy adjustment for retroactive enrollment.
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- 0% enrollment trend from the base period to the waiver periods.
- 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: **January 2015 through November 2017 enrollment was reviewed.** If multiple years are being used, please explain:
- **Enrollment trends were reviewed over multiple years.**
- f. [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- **SFY 2017 – July 1, 2016 to June 30, 2017**
- g. [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
- **The base year data is derived directly from the State's MMIS FFS claims and enrollment data warehouse. Also used are capitation payments made for the estimated 2,000 members that are currently in managed care that will be part of the populations covered under this waiver.**

For Conversion or Renewal Waivers:

- a. _____ [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. _____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. _____ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- d. _____ [Required] Explain any other variance in eligible member months from BY/R1 to P2: _____
- e. _____ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

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

For Initial Waivers:

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

- **All 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 be covered on a FFS basis.**

For Conversion or Renewal Waivers:

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

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

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

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

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration. **Costs included D5. Waiver Cost Projection reflect estimate fee for service spending without the waiver. Capitation rates for the populations that will be enrolled in managed care effective October 1, 2018 have not been calculated at this time. It is assumed spending under managed care will be cost effective relative to the projected FFS costs. Managed care savings are estimated to primarily occur within the inpatient and outpatient services categories, as managed care organizations shift care from a facility to ambulatory setting. Estimated savings for this waiver have not yet been determined. Savings estimates from projected expenditures will be included when the capitation rates are finalized.**

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. 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 information, administrative expenses as a percent of total medical expenses were calculated across all Medicaid populations. This percentage was applied to the base year total medical expense for the DCFS Youth and Special Needs Children**

populations. 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).

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		(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
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,751,500 or \$.97 PMPM R1</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1</i>
	<i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i>		<i>\$2,291,216 or 1.10 PMPM in P2</i>
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. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss

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

Basis and Method:

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

MCOs are not required to purchase reinsurance.

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

- ~~Projected costs in worksheet D.5. reflect estimated FFS costs without the waiver. Therefore, we have not illustrated incentives in the projection periods. Under the waiver, the State will withhold a portion of the capitation rate that MCOs may earn back by meeting annual quality measure targets. The withhold percentages are as follows and apply to both state plan and 1915(c) waiver services:~~
 - ~~Year 1: 0.75%~~
 - ~~Year 2: 1.38%~~

~~Actual withhold percentages are developed on a calendar year basis (0% 2018, 1% CY 2019, 1.5% CY 2020). Withhold amounts for each projection year have been weighted by the estimated managed care costs and applicable withhold percentage across calendar years. There are no incentives in the 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.

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

ii. Document the method for calculating incentives/bonuses,

- ~~The State will attribute a portion of the withhold to each quality measure.~~
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/MCOs/PAHPs do not exceed the Waiver Cost Projection.
 - ~~The State will monitor PMPM spending quarterly to ensure that payments to MCOs including any incentive payments do not exceed the capitation rates.~~

2. ____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and

cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. [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: 7.4% for the DCFS Youth, 8.8% for Special Needs Children. These trends reflect the trend from the midpoint of the base period to the midpoint of the first waiver projection year. Please document how that trend was calculated:

The actual trend from the base year to the current time period was not available. As such, we have developed long-term trend rates to move the data to the waiver period. Historical data incurred between January 1, 2015 and June 30, 2017 were used to project these trends and were stratified by major category of service (inpatient, ancillary, long-term care, outpatient, physician, pharmacy, and HCBS waiver services). The data included claims payment runout through November 2017. The data was completed to reflect fully incurred monthly amounts. Programmatic and policy changes that have occurred during the time period were reviewed for materially and deemed not to artificially impact trend development. A linear regression was applied to the historical per member per month incurred expenditures. Actuarial judgment was used to develop the final trend rates by between HCBS waiver services and all other services. The selections were informed by the regression results and other relevant information.

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

i. State historical cost increases. Please indicate the years on which the rates are based: January 2015 through June 2017. 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 P1 to P2 are consistent with the trend rate assumptions used to trend the base period (SFY 2017) to P1. Linear regression was used in the development of the assumptions.

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

~~• No adjustments have been made for programmatic or legislative changes occurring after the end of the base year period (July 1, 2017). To the extent changes do occur, the cost effectiveness projections will be amended to reflect these changes. Adjustments have been made for programmatic or legislative changes occurring after the end of the base year period (July 1, 2017). We will amend the cost effectiveness projections when the capitation rates have been finalized to reflect any programmatic changes. Further documentation will be provided with the amended filing when the implementation date of the managed care program is known~~

- c. ___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing

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

1. No adjustment was necessary and no change is anticipated. **Projected costs in D5 reflect estimated costs without the waiver.**
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**. _____

- ~~As the projected costs in D.5 are based on FFS cost projections in absence of the waiver, no incentive payments were assumed.~~ Under the waiver, the State will withhold a portion of the capitation rate that MCOs may earn back by meeting annual quality measure targets. The withhold percentages are as follows and apply to both state plan and 1915(c) waiver services:
 - Year 1: ~~0.75%~~ 1.13%
 - Year 2: ~~1.12%~~ 1.63%

Actual withhold percentages are developed on a calendar year basis (~~0% 2018,~~ 1% CY 2019, 1.5% CY 2020, 2.0% CY 2021). Withhold amounts for each projection year have been weighted by the estimated managed care costs and applicable withhold percentage across calendar years.

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

~~As the projected costs in D.5 are based on FFS cost projections in absence of the waiver, no incentive payments were assumed.~~
DCFS Youth: 48.1%
Special Needs Children: 46.6%

3. Explain any differences: The incentive costs are based on projected withhold amounts. The percentage of the capitation rate withheld is consistent between the two

MEGs. Differences in the incentive trend rate between MEGs is attributable to differences in the underlying benefit cost change between P1 and P2.

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

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

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

Method:

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

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

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

h. Copayments Adjustment: This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States

must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. **DCFS Youth and Special Needs Children do not have copays under the FFS delivery system.**

Basis and Method:

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

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

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

Method:

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

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

Basis and method:

1. 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**. **Pharmacy base year costs have been reduced by 56% and 31% to reflect supplemental and federal (OBRA90) pharmacy rebates received by the state for the DCFS Youth and Special Needs Children population, respectively. This assumption was based on rebates received by HFS during the fourth quarter of calendar year 2017.**
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. ___ Other (please describe):

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

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

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

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

- **Because the Base Year experience consists of populations that will be mandatorily enrolled in managed care, a selection adjustment was not made.**

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. 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. 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 incurred dates of July 1, 2016 through June 30, 2017 were used to develop the base year PMPM costs. The claims experience was paid through ~~November 30, 2017~~ May 31, 2018. The development method was used to calculate completion factors by service category. The following lists the impact of completion by MEG:
 - 7.8% 0.6% for the DCFS Youth MEG
 - 7.9% 1.1% for the Special Needs Children MEG

2. The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3. Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 2. ___ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes. **N/A**
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
1. ____ [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ____ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
 - i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.

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

Others:

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

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

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

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

For each change, please report the following:

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

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

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

D. Determine adjustment for Medicare Part D dual eligibles.

E. Other (please describe):

- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

- c. ___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.
- 1. ___ No adjustment was necessary and no change is anticipated.
 - 2. ___ An administrative adjustment was made.

- i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
- ii. ___ Cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
 - D. ___ Other (please describe):
- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.
- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
 - 1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2. ___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3)

trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

- i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years _____
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
- ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

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

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

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. _____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates

for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.

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

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

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

No changes in caseload mix were assumed.

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.