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

Kentucky Managed Care Organization Program

Kentucky Cabinet for Health and Family Services

September 30, 2020

Amended December 29, 2021

MMA Amendment Version
July 18, 2005

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

Facesheet

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

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

The **name of the waiver program** is **Kentucky Managed Care Organization Program**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

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

_X_ Amendment request for existing waiver, which modifies Section/Part D/Appendix D4 (pg 98)_

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

_X_ Document is replaced in full, with changes highlighted

Renewal request

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

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

Section A is ___ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Program Description from the previous waiver period.
___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Monitoring Plan from the previous waiver period.
___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of **5** years; effective **January 1, 2021** and ending **December 31, 2025**. (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 **Angie Parker** and can be reached by telephone at **(502) 564-9444 ext 2116, cell (502) 545-4491** or fax at **(502) 564-0509**, or e-mail at angelaw.parker**@ky.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.

Kentucky has no federally recognized tribes.

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).

Kentucky's Department for Medicaid Services (Department or DMS) implemented its Medicaid managed care program through an initial procurement process in 2011. This program was statewide with the exception of exclusion of Region 3. The Commonwealth awarded three year contracts through June 30, 2014 to the following managed care organizations (MCOs): Coventry, WellCare, and Kentucky Spirit. MCO operations began on November 1, 2011. In January 2013, these contracts were amended to increase contracted rates by 7%.

In 2013, the Department issued a second procurement for managed care contracts. With the new contracts, the Commonwealth added the ACA expansion population as a new eligibility group to be covered by the contracted MCOs. The Commonwealth awarded new contracts to five (5) MCOs, including the three (3) incumbent and two (2) additional MCOs. The new contracts were effective January 1, 2014 for the ACA expansion population and July 1, 2014 for existing members. Contracts were effective through June 2015 with three (3) one-year renewal options. Amendments to these contracts included addition of new expanded services required under the ACA and an increase in rates.

As of July 1, 2015, this waiver program included five (5) MCOs covering the waiver members statewide (in all eight (8) regions). Rates are developed by Cabinet for Health and Family Services' (CHFS') actuaries for two (2) Rate Areas. Rate Area A is composed entirely of Region 3, and Rate Area B is composed of Regions 1, 2, 4-8.

The Department issued a third procurement in January 2020. Contracts will be effective January 1, 2021 through December 31, 2024 with six (6) two-year renewal options. With these contracts, approximately 91% of Medicaid beneficiaries will continue to receive acute, primary and specialty services, including behavioral health and dental services, through the managed care program. The new contracts require all MCOs to adopt a single preferred drug list (PDL), as directed by the Department. Additionally, non-emergency medical transportation is not provided by the MCOs.

With the new contract awards, there are more extensive requirements for care management with required implementation of a population health management program with extensive focus on improving health outcomes. The Quality Strategy has also been updated to establish a process for addressing outcomes and social determinants of health.

Additionally, one MCO will provide and coordinate physical and behavioral health, dental care, and social services for children in foster care, dually committed youth, and children 18 years of age and under who are placed in Kentucky and eligible pursuant to the Interstate Compact on the Placement of Children (ICPC). The following eligibility groups may opt in and opt out of the MCO for the same services and coordination: adoption assistance, youth in Department of Juvenile Justice custody and Medicaid eligible, children and youth residing in Kentucky in an adoptive home (subject to age limitations) and who are receiving adoption assistance pursuant to the Interstate Compact on Adoption and Medical Assistance (ICAMA), and former foster care youth up to 26 years of age. The Department conducted an extensive planning and design process to develop this approach to address the unique needs of these populations with focus on improving health outcomes and strengthening the support to families in crisis.

A. Statutory Authority

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

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

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

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

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

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

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

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

B. Delivery Systems

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

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

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

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

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

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

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

   e. __ **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
      __ the same as stipulated in the state plan
      __ is different than stipulated in the state plan (please describe):

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

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

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

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

1. **Assurances.**

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

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

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

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

3. **Rural Exception.**

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

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

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

D. Geographic Areas Served by the Waiver

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

   X Statewide—all counties, zip codes, or regions of the State

   __ **Less than Statewide**

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

City/County/ Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 2	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 3	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 4	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 5	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 6	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 7	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare
Region 8	MCO	Aetna Better Health of Kentucky; Anthem, Humana Health Plan; UnitedHealthcare; WellCare of Kentucky; Passport Health Plan by Molina Healthcare

E. Populations Included in Waiver

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

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

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

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

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

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

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

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

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

__ Voluntary enrollment

X **Other** (Please define):

Children between the ages of 19 and 26 who formerly were in foster care and were receiving Medicaid benefits at the time that they aged out of foster care.

ACA Expansion Adults.

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.

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

__ **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.

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

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

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

__ **SCHIP Title XXI Children**—Medicaid beneficiaries who receive services through the SCHIP program.

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

X **Other** (Please define):

Individuals who shall spend down to meet eligibility income criteria;
Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) or Qualified Disabled Working Individuals (QDWIs);
Time limited coverage for illegal aliens for Emergency Medical Conditions;
Working Disabled Program;
Individuals who are eligible for the Breast or Cervical Cancer Treatment Program;
Individuals otherwise eligible while incarcerated in a correction facility.

Additionally, individuals who obtain Medicaid eligibility through receipt of Supplemental Security Income payments (SSI) will not have retroactive eligibility periods covered under this waiver. The retroactive eligibility period for SSI members will be covered through the state's Medicaid fee for service program. Because the retroactive eligibility period for SSI members can be up to several years long and is highly variable, the Commonwealth does not believe actuarially sound predictable rates could be developed for this population.

F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

- Section 1902(s) – adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC

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

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

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

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

   X The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
   __ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
   __ The State will pay for all family planning services, whether provided by network or out-of-network providers.
   __ Other (please explain):

   __ Family planning services are not included under the waiver.

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

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

The Department requires MCOs to contract with at least one (1) FQHC and one (1) Rural Health Center (RHC) for each Medicaid Region, where available. If an MCO is not able to reach agreement with these providers, the MCO must submit documentation to the Department for approval that indicates adequate services and service sites will be provided to meet enrollee needs without contracting with these specified providers.

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

5. **EPSDT Requirements.**

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

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

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

7. **Self-referrals.**

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

The Department requires MCOs to ensure enrollees have direct access without restriction of choice of a qualified provider for the following services within the MCO's network:

(1) Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;
(2) Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;
(3) Voluntary family planning in accordance with federal and state laws and judicial opinion;
(4) Maternity care for enrollees under eighteen (18) years of age;
(5) Immunizations to enrollees under twenty-one (21) years of age;
(6) Sexually transmitted disease screening, evaluation and treatment;
(7) Tuberculosis screening, evaluation and treatment;

(8) Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;
(9) Chiropractic services;
(10) Specialists for enrollees with special health care needs as appropriate for condition and identified needs when determined through assessment to need a course of treatment or regular care monitoring;
(11) Women's health specialists.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

      1.__ PCPs (please describe):
      2.__ Specialists (please describe):
      3.__ Ancillary providers (please describe):
      4.__ Dental (please describe):
      5.__ Hospitals (please describe):

6.__ Mental Health (please describe):
7.__ Pharmacies (please describe):
8.__ Substance Abuse Treatment Providers (please describe):
9.__ Other providers (please describe):

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

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

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

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

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

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

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

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

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

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

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

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.** The following items are required.

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

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

Enrollees with special health care needs include:

1) Children in/or receiving Foster Care or Adoption Assistance;
2) Blind/Disabled children under age nineteen (19) and related populations eligible for SSI;
3) Adults over the age of sixty-five (65);
4) Individuals who are homeless (upon identification);
5) Individuals with chronic physical health and/or behavioral health illnesses;
6) Children receiving EPSDT Special Services;
7) Children receiving services in a Pediatric Prescribed Extended Care facility or unit;
8) Adults in state guardianship status;

9) Individuals with serious mental illness (SMI) who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community based housing.

Children receiving foster care or adoption assistance, blind/disabled children under age nineteen (19) and related populations eligible for SSI, and adults in guardianship status are identified by eligibility codes in the member file transmitted to the MCOs. The Department also provides MCOs with the prior year's claims data to identify individuals with chronic illnesses.

MCOs must have written policies and procedures governing how enrollees with the above multiple and complex physical and behavioral health care needs are further identified, including internal operational processes to target enrollees for screening and identifying individuals with special health care needs. Additionally, MCOs are required to have an outreach plan for individuals who are homeless.

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

MCOs are required to use appropriate health professionals to assess each enrollee identified as having special health care needs to identify ongoing special conditions that require a course of treatment or regular care monitoring.

MCOs must:

1) Develop and distribute to individuals with special health care needs, caregivers, parents and/or legal guardians, information and materials specific to the needs of the Enrollee, as appropriate, including health educational material as appropriate to assist in understanding their chronic illness.
2) Have in place policies governing the mechanisms utilized to identify, screen and assess individuals with special health care needs.
3) Produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.
4) Develop practice guidelines and other criteria that consider the needs of individuals with special health care needs and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.

For individuals in adult guardianship, MCOs must coordinate with the Department for Aging and Independent Living to determine and meet each individual's medical needs and identify the need for placement in Case Management, as set forth in the enrollee's service plan. MCOs must provide ongoing Care Coordination for these Enrollees whether or not enrolled in Case

Management to ensure access to needed social, community, medical and behavioral health Services.

The MCO providing services and coordination for children in foster care, dually committed youth, children receiving adoption assistance, former foster youth, and children and youth receiving services pursuant to ICPC and ICAMA must coordinate with the Department for Community Based Services to assure enrollees receive assessments, such as trauma assessments, health risk assessments, and clinical assessments (e.g., medical and dental). The MCO must assign an Assessment Team for each enrollee to ensure assessments are received within required timeframes and used to develop care plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office **on June 3, 2011 and the Department submitted an updated draft for review and approval on August, 5, 2019**.

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	Island Peer Review Organization (IPRO)	Annual Review	As referenced in 42 CFR 438.358	As described in Section B. Part II

2. **Assurances for PAHP program.**

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

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

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

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

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

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

1.__ Provide education and informal mailings to beneficiaries and PCCMs;
2.__ Initiate telephone and/or mail inquiries and follow-up;
3.__ Request PCCM's response to identified problems;
4.__ Refer to program staff for further investigation;
5.__ Send warning letters to PCCMs;
6.__ Refer to State's medical staff for investigation;
7.__ Institute corrective action plans and follow-up;
8.__ Change an enrollee's PCCM;
9.__ Institute a restriction on the types of enrollees;
10.__ Further limit the number of assignments;
11.__ Ban new assignments;
12.__ Transfer some or all assignments to different PCCMs;
13.__ Suspend or terminate PCCM agreement;
14.__ Suspend or terminate as Medicaid providers; and
15.__ Other (explain):

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

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

1. __ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. __ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. __ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   A. __ Initial credentialing
   B. __ Performance measures, including those obtained through the following (check all that apply):
      __ The utilization management system.
      __ The complaint and appeals system.
      __ Enrollee surveys.
      __ Other (please describe):
4. __ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. __ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. __ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. __ Other (please describe):

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances.**

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

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

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

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

2. **Details.**

   a. **Scope of Marketing**

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

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

         MCOs may use mail, mass media and community oriented marketing directed at potential enrollees, subject to the Department's prior approval. All marketing materials are to be approved by the Department prior to distribution.

No indirect door-to-door, telephone, email, texting or other cold-call marketing activities are permitted.

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

   An MCO may direct market to enrollees who are enrolled with the MCO through the use of pamphlets, brochures, fact sheets, posters, and application packets. All materials are to be approved by the Department prior to distribution.

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

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

   MCOs are prohibited from:
   1) Providing cash to enrollees or potential enrollees, except for stipends, in an amount approved by the State and reimbursement of expenses provided to enrollees for participation on committees or advisory groups;
   2) providing gifts or incentives to enrollees or potential enrollees unless such gifts or incentives are also provided to the general public, do not exceed ten dollars per individual gift or incentive, and have been pre-approved by the State;
   3) Providing gifts or incentives to enrollees unless such gifts or incentives are provided conditionally based on the enrollee receiving preventive care or other covered services, are not in the form of cash or an instrument that may be converted easily to cash, and have been pre-approved by the Department.
   4) Seeking to influence a potential enrollee's enrollment with the MCO in conjunction with the sale of any private insurance;
   5) Inducing providers or employees of the Department to reveal confidential information regarding enrollees or otherwise use such confidential information in a fraudulent manner;
   6) Threatening, coercing or making untruthful or misleading statements to potential enrollees or enrollees regarding the merits of enrollment with the MCO or any other plan.

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

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

The Department requires MCOs to provide marketing materials in English, Spanish, and each prevalent non-English language. Prevalent non-English language means any non-English language spoken by 5% or more of the population in Kentucky and any non-English language spoken by 5% of more of the population in a county served by the MCO.

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

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

Based on the latest U.S. Census, 2018 American Community Survey, no regions in Kentucky have significant ethnic populations. Households that speak other than English are less than 5% statewide, with Spanish being the only language spoken by any significant percentage of population. Other languages combined comprise less than 3% of the total population.

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

iii. __ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

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

2. **Details.**

a. Non-English Languages

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

English, Spanish, and each Prevalent Non-English Language.

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 **[X]** percent or more of the potential enrollee/ enrollee population.
3. **X** Other (please explain):

Prevalent non-English language means any non-English language spoken by 5% or more of the population in Kentucky and any non-English language spoken by 5% or more of the population in a county served by the MCO.

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

The Department requires that MCOs provide:

1) Appropriate foreign language and/or oral interpreters free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education and otherwise comply with 42 C.F.R. 438.10(d).
2) Oral interpretation for all non-English languages.
3) Staff who are able to respond to special communication needs of the disabled, blind, deaf, and aged.
4) Enrollee handbooks that contain information on the availability of oral interpretation services for all languages, written translations in English, Spanish, and each prevalent non-English language as well as for the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services.

The State will provide on-site translation services or have telephonic translation services available in the local eligibility offices.

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

All individuals determined Medicaid eligible receive information about enrollment into managed care upon determination, including an enrollment packet and information about each of the contracted MCOs. This explanation, which includes a description of the managed care program, is also available on the Department's website 24/7 for enrollees and interested parties. MCOs provide an enrollee handbook based on a model handbook provided by the Department. Materials are available in English and Spanish. Telephonic translation services will be provided. Additionally, the Department contracts with a vendor that provides a call center for enrollees and potential enrollees to call if they have questions.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

X State
__ Contractor (please specify):

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

c. Enrollee Information

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

(i) **X** the State

(ii) **X** State contractor (please specify): Conduent provides a member call center to answer enrollee questions about MCO enrollment.
(iii) **X** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

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

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

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

The Department uses various methods to outreach to stakeholders to inform them about the managed care program. Key approaches include:

1) Customer service through a toll-free hotline;
2) Written materials and updates;
3) Web-based information and email customer response;
4) Support for the work of local health and human services partners with information, advocacy and updated materials and similar activities.

b. Administration of Enrollment Process.

X State staff conducts the enrollment process.

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

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

Broker name: [ ]

Please list the functions that the contractor will perform:

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

State staff are responsible for the enrollment process and choice counseling for newly enrolling members. During the open enrollment process, state staff respond to member questions about MCO choice. Additionally, the Department contracts with Conduent to provide a member call center. Members may also contact the call center to answer questions during open enrollment.

__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.):

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

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

i. **X** Potential enrollees will have **one** day to choose a plan.

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

Enrollees may choose an MCO immediately after the eligibility determination process is complete whether they enroll in person at a county eligibility office or online through the State's website, benefind, which allows easy access to public assistance benefits and information 24/7 through an online application and account.

For individuals who do not voluntarily select an MCO, the State will make an auto-assignment. The auto-assignment methodology considers the following:

1) Keeping the Family Together: Assign Enrollees of a family to the same MCO;
2) Continuity of Care: Preserve the family's pre-established relationship with providers to the extent possible;
3) MCO Competition: Equitable distribution of enrollees among the MCOs.

In order to give due consideration to children and individuals with specialized health care needs, a scoring system is utilized to determine appropriate assignment.

Newborn infants of non-presumptive eligibility enrollees shall be deemed eligible and automatically enrolled in the mother's MCO as an individual enrollee for sixty (60) days.

Enrollees have ninety (90) days after initial enrollment and MCO assignment to request to change to a new MCO.

__ 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 [X] months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

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

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

d. Disenrollment:

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

i. **X** Enrollee submits request to State.

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

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

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

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

An Enrollee may request Disenrollment only with cause pursuant to 42 C.F.R. 438.56. The Contractor shall follow the Disenrollment for Cause process as defined by the Department.

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

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

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

An MCO may request disenrollment of an enrollee when, pursuant to 42 C.F.R. 438.56, the enrollee is: (1) found guilty of fraud in a court of law or administratively determined to have committed fraud related to the Medicaid program; (2) is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers to either the MCO, its agents, or its providers;

(3) admitted to a nursing facility for more than 31 days; (4) incarcerated in a correctional facility; (5) no longer qualifies for medical assistance; or (6) cannot be located.

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

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

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

D. Enrollee Rights

1. Assurances.

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

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

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

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

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

E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:
   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

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

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

b. Timeframes

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **60** days (between 20 and 90) from the date of receiving a notice of adverse action from an MCO.

X The State's timeframe within which an enrollee must file a **grievance** is **at any time**.

c. Special Needs

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

MCOs are required by contract to provide their enrollees opportunities to grieve or appeal MCO decisions. At a minimum, the MCO must overcome communication and other barriers that would prevent an individual with special needs from participating in the process. The MCO must address an enrollee's issues within a timeframe that is appropriate for the member's medical condition.

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 **[X]** PCCM and/or **[X]** PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

__ The grievance procedures is operated by:
- __ the State
- __ the State's contractor (please identify):
- __ the PCCM
- __ the PAHP.

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

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

__ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: **[X]** (please specify for each type of request for review)

__ Has time frames for resolving requests for review. Specify the time period set: **[X]** (please specify for each type of request for review)

__ Establishes and maintains an expedited review process for the following reasons: [**X**]. Specify the time frame set by the State for this process **[X]**.

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

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

__ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

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

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

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

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under

"Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

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

I: Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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

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

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)

X NCQA
__ JCAHO
__ AAAHC
__ Other (please describe):

MCOs must have and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line. Annually the Contractor shall submit the Final Auditor's Report issued by the NCQA certified audit organization.

c. Consumer Self-Report data

X CAHPS (please identify which one(s)):

MCOs must conduct an annual survey of enrollees' and providers' satisfaction with the quality of services provided and their degree of access to services. The enrollee satisfaction survey requirements are satisfied by the MCO participating in the Agency for Health Research and Quality's (AHRQ) current CAHPS for Medicaid Adults and

Children with a separate sample and survey for CHIP Enrollees, administered by an NCQA certified survey vendor. The MCO shall provide a copy of the current CAHPS survey tool to the Department. Annually, the MCO shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.

MCOs must establish and maintain ongoing Quality and Member Access Committees (QMACs) composed of enrollees, individuals from consumer advocacy groups or the community representing the interests of the enrollee populations. The Committees must also include community-based organizations representation.

__ State-developed survey
__ Disenrollment survey
__ Consumer/beneficiary focus groups

d. Data Analysis (non-claims)

DMS requires ongoing and ad hoc reporting to include data analysis from the MCOs. Additionally, DMS and its external quality review organization (EQRO) develop additional reporting and data analyses.

__ Denials of referral requests
X Disenrollment requests by enrollee
  X From plan
  X From PCP within plan
X Grievances and appeals data
X PCP termination rates and reasons
X Other (please describe): Detailed reporting package to address MCO operations specific to enrollees and providers (provider network adequacy reporting, population health management reports, utilization management reports, enrollee services reports, quality management reports, among others)

e. **X** Enrollee Hotlines operated by State

The MCO shall have an enrollee services function that includes a call center which is staffed and available by telephone Monday through Friday 7:00 am to 7:00 pm Eastern Time (ET). The call center must meet required standards for call center abandonment rate, blockage rate and average speed of answer for all MCO programs with the exception of behavioral health.

The MCO must have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel 24 hours a day, seven days a week, 365 days a year (24/7/365), toll-free throughout the Commonwealth. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies. Emergency and crisis behavioral

health services may be arranged through mobile crisis teams. Face-to-face Emergency Services shall be available 24/7. The Behavioral Health Services Hotline shall not be answered by any automated means.

The MCO also has telecommunication device capability for the deaf to assist members in obtaining and appropriately using Emergency and Urgent Care.

MCOs must provide enrollee call center statistics on required metrics as measured by monthly averages and information about timeliness of resolution of requests, including reporting of average call volume statistics by monthly averages to assist in identifying spikes in calls against performance.

The Department monitors call center performance and issues Letters of Concern or corrective action if an MCO is not meeting requirements.

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

The Department contracts with an EQRO to conduct focused studies of MCO enrollees or services to include detailed investigations of certain aspects of clinical or non-clinical services at a point in time to answer specified questions. The focused studies are centered on specific clinical areas of interest including primary and preventive care, chronic care, acute care, ambulatory care sensitive conditions and/or behavioral issues. They may also evaluate health service delivery issues such as coordination, continuity, access and availability of needed services. Two focused studies are designed and implemented per contract year in collaboration with the EQRO, the MCO and the Department.

g. **X** Geographic mapping of provider network

The MCOs must provide geographical access reports addressing all provider types specified by the State to support network adequacy monitoring.

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

The Department contracted with Deloitte Consulting to provide an independent assessment of the initial waiver period. Deloitte provided a findings report in 2014. The Department contracted with Myers and Stauffer LLC to conduct an additional independent assessment prior to submission of this renewal waiver application. Myers and Stauffer submitted its findings report in 2020 for the time period July 1, 2017 to June 30, 2019.

Additionally, IPRO provides external quality review (EQR) reports as required under Title XIX of the Social Security Act, Section 1902(a)(30)(C) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services. A technical report is provided annually and is reviewed by and acted upon as necessary by the DMS and submitted to CMS by April 30 of each year.

i. **X** Measurement of any disparities by racial or ethnic groups

Measurement of racial or ethnic disparities are incorporated into focused studies that are conducted by the EQRO over the course of the waiver.

Additionally, the Department will specify the required performance and outcomes measures that the MCOs must address, including Health Care Effectiveness Data and Information Set (HEDIS) measures and Kentucky-specific measures. MCOs must make comparisons across data for each measure by the Medicaid geographic regions, eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the State to the MCO. The MCO shall incorporate consideration of social determinants of health into the process for analyzing data to support population health management. Reported information may be used to determine disparities in health care.

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

Each MCO must submit to the Department a Provider Network Plan that demonstrates the MCO's capacity to serve its anticipated enrollment in consideration of all required provider types. The Department will monitor the MCO's compliance with provider network requirements and standards on an ongoing basis using data from the MCO's monthly provider file, geographic access data reports, enrollment data, and other required MCO reporting. The Department will monitor that the MCO has a sufficient number and distribution of providers for each provider type. The Department may also periodically phone providers to confirm the provider is contracted with the MCO. The Department will also monitor data such as provider satisfaction survey findings, complaints and appeals data for indications that problems exist with access to providers. Providers in the MCO's network who are not accepting enrollees shall not be included in an assessment of network adequacy and access. If at any time, the MCO or the Department determine that the MCO's provider network is not adequate to comply with the standards for 95% of its enrollees, the MCO or Department shall notify the other and within 15 business days the MCO shall submit a corrective action plan to remedy the deficiency.

Additionally, the Department requires MCOs to monitor provider compliance with access requirements and take corrective action for failure to comply. MCOs must conduct monitoring such as surveys and office visits to monitor compliance with

appointment waiting time standards and shall report findings and corrective actions to the Department.

k. **X** Ombudsman

MCOs must cooperate with the CHFS' independent ombudsman program, including providing immediate access to an enrollee's records when written enrollee consent is provided.

l. **X** On-site review

IPRO, the contracted EQRO vendor, performs an annual on-site review of each MCO to assess the MCO compliance with state and federal standards regarding the following operational areas: availability and access of services; continuity and coordination of care; coverage and authorization of services; establishment of provider networks, enrollee rights; pharmacy; enrollment and disenrollment; grievance systems; subcontract relationships and delegation; use of practice guidelines; health information systems, mechanisms to detect under and over-utilization of services and mechanisms to detect fraud and abuse. IPRO prepares and discusses the report of the findings with the DMS to determine if any actions are needed.

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

The MCO shall comply with 42 C.F.R. 438.330(d) to conduct performance improvement projects (PIPs) which focus on both clinical and non-clinical areas. PIPs focused on clinical areas as designated by the Department may address preventive and chronic health care needs of the whole enrollee population and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special health care needs, race, ethnicity, gender and age. PIPs focused on non-clinical areas as designated by the Department may address issues such as improving the quality, availability, and accessibility of services provided by the MCO to enrollees and providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.

MCOs must report the status and results of all required PIPs to the Department as required in 42 C.F.R. 438.330(c)(3) with sufficient detail for the Department to evaluate the reliability and validity of the data and conclusions drawn.

X Clinical
X Non-clinical

n. **X** Performance measures [**Required** for MCO/PIHP]

MCOs are required to collect and report HEDIS data annually, including separate data for the Kentucky CHIP population. After completion of the MCO's annual HEDIS data collection, reporting and performance measure audit, the MCO must submit to the Department the final auditor's report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool by no later than each August 31. For each measure reported, the MCO must trend results from all previous years, and where applicable, indicate benchmark data and performance goals established for the reporting year shall be indicated. For all reportable effectiveness of care and access/availability of care measures, MCOs must make comparisons across each measure by Medicaid region, Medicaid eligibility category, race, ethnicity, gender, and age. Annually, the MCO and the Department will select a subset of targeted performance from the HEDIS reported measures and Kentucky-specific measures on which the Department will evaluate the MCO's performance.

The Department's EQRO provides analysis of measurement and reports findings and recommendations for improvement.

- **X** Process
- **X** Health status/outcomes
- **X** Access/availability of care
- **X** Use of services/utilization
- **X** Health plan stability/financial/cost of care
- **X** Health plan/provider characteristics
- **X** Beneficiary characteristics

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

As discussed under network adequacy, this process takes place on a quarterly basis to include an analysis to address the access to care standards. EQRO studies include analyses of provider numbers and types.

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

Enrollee to PCP ratios shall not exceed 1500:1. The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and underutilization of services, and the development of user-defined reporting criteria and standards. This system profiles utilization of providers and members and compares them against experience and norms for comparable individuals.

q. **X** Provider Self-report data

MCOs must conduct an annual survey of provider satisfaction with the quality of services and access to services.

X Survey of providers
_ Focus groups

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

The EQRO performs an annual review of primary care providers and selected specialists, dentists and behavioral health providers to assess availability and access to providers.

MCOs retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the MCO and Department policies.

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

MCOs must have a comprehensive utilization management program that reviews services for medical necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. MCOs must comply with federal and State regulations when selecting medical necessity criteria. MCOs must adopt Interqual or MCG (Milliman) as the primary medical/surgical criteria for Medical Necessity except that the MCOs must utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual or MCG does not cover a behavioral health service, MCOs must adopt the following standardized tools for medical necessity determinations: (1) Level of Care Utilization System (adults); (2) Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS) (children); and (3) Early Childhood Service Intensity Instrument (ECSII) (young children). DMS reviews any clinical criteria the MCO utilizes outside of InterQual or MCG.

The MCOs must report on utilization data quarterly, as well as, an annual utilization management program evaluation.

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.

X 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.

X 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):

1. NCQA Accreditation for Participation

- **Strategy:** MCOs must have and maintain NCQA accreditation for their Medicaid product lines as well as NCQA/MBHO accreditation. MCOs are required to provide certificate of accreditation with a copy of completed survey reports every three years, including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.

  The Department also requires subcontractors with NCQA/URAC or other national accreditation provide copies of current certificate of accreditation together with a copy of survey reports.

  The Department uses materials to monitor each MCOs' compliance with accreditation requirements to identify deficiencies.

- **Confirmation it was conducted as described**:

  X Yes
  __ No. Please explain:

- **Summary of results:** MCOs have maintained their required accreditations.

- **Problems identified:** None.

- **Corrective action (plan/provider level):** None.

- **Program change (system-wide level):** None.

2. Consumer Self-Report data

- **Strategy:** MCOs must conduct annual enrollee CAHPS surveys for Adults and Children, and separate surveys for CHIP enrollees, that are administered by an NCQA certified survey vendor.

The Department reviews the survey results each year, and results are also evaluated by the EQRO and addressed in the EQRO Technical reports.

MCOs also conduct special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment, and services.

MCOs have Quality and Member Access Committees (QMACs) to ensure enrollee interests are taken into account in ongoing program operations. QMACs include enrollees, individuals from consumer advocacy groups or the community representing the interests of the enrollee populations. The Committees must also include community-based organizations representation.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** MCOs showed satisfaction meeting or exceeding the national 50th percentile for various Adult and Child CAHPs measures, as well as some achievement of measures at or above the 90th percentile.

- **Problems identified:** Some measures are at or below the national 25th percentile. For example, three MCOs had Rating of Health Plan below the national 25th percentile for the Child CAHPS survey.

- **Corrective action (plan/provider level):** The state continues to monitor low ratings.

- **Program change (system-wide level):** MCO contracts to begin January 2021 include increased focus on improving health outcomes for enrollees. Additionally, there is an increased requirement for collaboration across the MCOs with the Department to enhance reporting, to identify provider network issues, and to have collaborative performance improvements projects (PIPs). One goal for these programmatic changes is to improve enrollee satisfaction with the care they receive.

3. Data Analysis (non-claims)

- **Strategy:** MCOs are contractually required to submit ongoing and ad hoc reporting. DMS uses the information to support determinations of MCO compliance and decisions by the Department's Corrective Action Plan Committee to require corrective action and to recommend penalties.

  Over time, the Department has discontinued some reporting requirements, and instead generates some reporting internally, such as provider network analyses.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Compliance review findings showed that each of the five MCOs submitted quarterly Quality Assessment and Performance Improvement Work Plans.

- **Problems identified:** None.

- **Corrective action (plan/provider level):** Not applicable.

- **Program change (system-wide level):** With new contracts to begin in January 2021, the Department is collaborating extensively with MCOs to prepare a comprehensive reporting package that is focused on key operational areas that will result in standardized reporting definitions and specifications used across all MCOs. This effort will result in detailed reporting to support Department oversight of program quality and outcomes, access, and costs.

4. Enrollee Hotlines operated by State

- **Strategy:** The Department requires the MCOs to have enrollee call centers that meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all MCO programs with the exception of behavioral health. The MCOs must have emergency and crisis Behavioral Health Services Hotline that is available 24/7 and that is not answered by any automated means.

  The Department reviews MCO reporting of call center statistics on required metrics as measured by monthly averages and information about timeliness of resolution of requests, including reporting of average call volume statistics by monthly averages to assist in identifying spikes in calls against performance.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** Call centers are evaluated as part of the annual compliance review. No issues identified for the 2020 compliance review.

- **Problems identified:** The prior year's compliance reviews included recommendations for one MCO to improve member satisfaction, and for another MCO to improve the availability of board certified providers in primary and specialty care.

- **Corrective action (plan/provider level):** MCOs with identified problems and resulting recommendations implemented actions to focus on member complaints, grievances and appeals related to areas such as member calls/inquiries, satisfaction, and provider availability.

- **Program change (system-wide level):** As noted above, the Department is collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for contracts to begin January 1, 2021, including call center reporting.

5. Focused Studies

- **Strategy:** The Department contracts with an EQRO to conduct focused studies of MCO enrollees or services to include detailed investigations of certain aspects of clinical or non-clinical services at a point in time to answer specified questions. The EQRO proposes topics to the Department for review and approval, and at the direction of the Department two focused studies are designed and implemented per contract year in collaboration with the EQRO, the MCO and the Department.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:**
  For each focused study, the EQRO provides a findings report and identified opportunities for Department and/or MCO action. The Department shares the study recommendations with the MCOs. In collaboration with the Department, each MCO develops implementation plans, as needed, to respond to recommendations. Focused studies have been conducted for diabetes and social determinants of health (SDOH) as described below.

  1. **Diabetes:** This focused study highlights opportunities for MCOs to improve the quality of care provided to Kentucky Medicaid Managed Care (MMC) enrollees with diabetes. Enhanced MCO interventions are warranted to increase referrals to endocrinologists and diabetic specialists in accordance with clinical guidelines recommendations and to increase receipt of DSMES among enrollees newly diagnosed with T2DM. In addition, provider education for evidence-based care should be based upon guideline recommendations for T1DM and T2DM early symptom recognition and screening in children and adults, diagnostic testing, HbA1c monitoring, management and referral for specialist evaluation, as well as care gap reports that identify enrollees at risk for diabetic complications.

  2. **SDOH:** This focused study highlights opportunities for MCOs to improve the quality of care provided to Kentucky MMC enrollees by conducting universal screening for social determinants of health, referring enrollees to SDOH resources, coordinating with primary care providers (PCPs), and providing follow-up to ensure that these

services meet enrollee needs. Findings also highlight the importance of early diagnosis and management of behavioral health problems. The multifactorial and overlapping nature of both SDOH and behavioral health problems supports an integrated approach to address enrollee needs. Thus, the following recommendations include specific recommendations for enhanced SDOH screening and referral, as well as performance improvement projects (PIPs) to address behavioral health conditions.

- **Problems identified:**

1. **Diabetes:** Compared to Kentucky MMC adults, a greater proportion of children with diabetic complications have access to specialist care, yet access is variable across MCOs for both adults and children. Long-term T1DM and T2DM complications prevalence was greater among adults (72.4% and 48.3%, respectively) than among children (18.25 and 19.6%, respectively), whereas short-term T1DM and T2DM complications prevalence was greater among children (17.2% and 10.4%, respectively) than among adults (13.2% and 2.2%, respectively). Obesity, physical disability, and serious mental illness are prevalent among Kentucky MMC enrollees with diabetes. The vast majority of Kentucky MMC enrollees newly diagnosed with T2DM were without a claim for DSMES. There is a substantial gap in evidence-based diabetes care receipt because 4 of the 5 MCOs did not achieve the Quality Compass 50th percentile for HbA1c testing.

2. **SDOH:** The current study is consistent with prior research findings that SDOH increase the risk for hospital readmission, and adds to the scientific knowledge the finding that SDOH increase the risk for multiple ED visits. Increased risk was observed for the following most prevalent SDOH domains: housing, social connection/isolation, frailty, and adverse childhood experiences (ACE). An important new insight from this study is the finding that the Kentucky MMC enrollees with suicidal ideation composed more than one-third of the sub-population with SDOH-coded issues who are high utilizers (with a 30-day hospital readmission and/or six or more ED visit within 12 months). MCO chart review findings revealed that most Kentucky MMC high utilizers were without current and comprehensive SDOH assessment, interventions, and follow-up. As shown in multiple prior IPRO/DMS focused studies, substance use disorder is a risk factor for high utilization of hospital services. Multiple high-risk chronic physical conditions also increase the risk for hospital readmission and multiple ED visits. Lack of PCP visits incurs almost a three times greater risk for the outcome of high utilization; however, multiple PCP visits is associated with an even greater risk.

- **Corrective action (plan/provider level):** None; however, findings were used to inform development and implementation of PIPs to improve Diabetes Management and Social Determinants of Health Evaluations and Referrals.

- **Program change (system-wide level):**

  With the MCO contracts to be effective January 1, 2021, extensive changes have been made to requirements for focus on health outcomes and population health management with detailed care management for enrollees identified as in need. Additionally PIPs, such as those to improve diabetes management and to improve assessment and referral for SDOH are being initiated to help impact outcomes.

6. Geographic mapping of provider network

- **Strategy:** The MCOs provide geographical access reports addressing all provider types specified by the State to support network adequacy monitoring. The Department also creates monthly network reporting for analysis to work to confirm information provided by the MCOs.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** A compliance review found that MCOs submitted the required reports.

- **Problems identified:** More detailed provider type definitions and reporting specifications are merited.

- **Corrective action (plan/provider level):** None.

- **Program change (system-wide level):** As noted above, the Department is collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for January 2021 contracts, including extensive changes to provider network reporting. The work includes more detailed provider type definitions and reporting specifications for geographic mapping reports, as well as other required provider network reporting. This effort will improve standardization across all MCO reporting and help the Department to have increased confidence in the reliability of the analyses provided by the MCOs.

7. Independent Assessment

- **Strategy:** DMS contracted a vendor to complete an independent assessment of the Kentucky Medicaid Managed Care Program in 2020 to submit with this waiver renewal application for the time period of July 1, 2017 to June 30, 2019. This is the second independent assessment completed for the program. The first assessment was completed in 2014.

  Additionally, IPRO provides federal mandated and optional external quality review (EQR) services. A technical report is provided annually and is reviewed by and acted

upon as necessary by the DMS and submitted to CMS by April 30 of each year. Results of the reviews are also posted on the DMS website.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Please see the attached Independent Assessment Report.

- **Problems identified:** Please see the attached Independent Assessment Report.

- **Corrective action (plan/provider level):** None, although the Department is considering opportunities based on recommendations outlined in the report.

- **Program change (system-wide level):** None. However, prior to the Independent Assessment, the Department has made significant changes to MCO contracts to begin January 2021 to address some of the problems and recommendations that are outlined in the report.

8. Measurement of any disparities by racial or ethnic groups

- **Strategy:** Measurement of racial or ethnic disparities are incorporated into focused studies that are conducted by the EQRO over the course of the waiver. As noted above, the EQRO reviews focused studies and provides recommendations to the Department. MCOs develop implementations plans to address recommendations, as needed.

  For performance and outcomes measures, MCOs must make comparisons across data for each measure, including by race or ethnicity. The Department and MCOs may use reported information to determine disparities in health care.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** As previously described, focused studies on the topics of Diabetes Management and Social Determinants of Health Assessment and Referral were conducted. Findings were stratified by race.

- **Problems identified:** No significant associations between race and study outcomes were detected.

- **Corrective action (plan/provider level):** None, but will continue to monitor.

- **Program change (system-wide level):** None.

9. Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]

- **Strategy:** DMS requires MCOs to develop and maintain comprehensive provider networks to provide services to enrollees. The Department requires MCOs to conduct annual provider satisfaction surveys, and to report the survey methodology, summary of responses and findings, and initiatives they will implement to address findings.

  DMS also reviews appointment wait times through annual focused Secret Shopper Surveys by provider type conducted by the EQRO. DMS may also periodically phone providers to confirm the provider is contracted with the MCO.

  The Department monitors the MCO's compliance with provider network requirements and standards on an ongoing basis using data from the above mentioned information and MCO's monthly provider file, geographic access data reports, enrollment data, and other data such as complaints and appeals. Where needed, corrective actions are required and penalties may be applied. Additionally, the Department requires MCOs to monitor provider compliance with access requirements and take corrective action for failure to comply.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Secret shopper surveys found that overall 79.5% of endocrinologists for routine calls and 79.3% of endocrinologists for urgent calls were able to be contacted with 14.5% endocrinologists for routine calls and 7.8% endocrinologists for urgent calls able to schedule an appointment within the corresponding timeliness standards (i.e., 30 days and 48 hours, respectively).

- **Problems identified:** None; continue to monitor.

- **Corrective action (plan/provider level):** None.

- **Program change (system-wide level):** The Department made extensive changes to Provider Network requirements for contracts beginning January 2021. MCOs must submit and provide ongoing updates to a Provider Network Plan for Department approval. New contracts also require a formal process for MCOs to request exceptions to provider network requirements for conditions in the Commonwealth that may create challenges in meeting network adequacy requirements (e.g., workforce shortages for specific provider types in specific counties). Exception requests will generally be time limited and must include a detailed plan to address enrollees' needs and to remedy the network deficiency. The contract requires MCOs to partner with the Department to understand the health needs of Kentucky and to develop innovative solutions to develop

or foster provider capacity or otherwise meet the healthcare needs of enrollees and the requirements of the Contract.

Additionally, new contracts provide requirements for use of telehealth as a tool or facilitating access to needed services in a clinically appropriate manner that are not available within the Contractor's Provider Network and in accordance with state regulations.

As described earlier, the Department is collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for January 2021 contracts, including extensive changes to provider network reporting. The work includes more detailed provider type definitions and reporting specifications for geographic mapping reports, as well as other required provider network reporting.

10. Ombudsman

- **Strategy:** MCOs must cooperate with the CHFS' independent ombudsman program, including providing immediate access to an enrollee's records when written enrollee consent is provided.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** MCOs cooperate with the Ombudsman office when if/when an issue needs resolution.

- **Problems identified:** None.

- **Corrective action (plan/provider level):** None.

- **Program change (system-wide level):** None.

11. On-site review

- **Strategy:** The Department's EQRO performs an annual on-site review of each MCO to assess compliance with state and federal standards regarding the following operational areas: availability and access of services; continuity and coordination of care; coverage and authorization of services; establishment of provider networks, enrollee rights; pharmacy; enrollment and disenrollment; grievance systems; subcontract relationships and delegation; use of practice guidelines; health information systems, mechanisms to detect under and over-utilization of services and mechanisms to detect fraud and abuse. IPRO provides a findings report to DMS to determine if any actions are needed.

Additionally, the Department is conducting a readiness review of all MCOs in preparation for new contracts effective January 1, 2021. The review includes virtual reviews (as approved by CMS in lieu of onsite visits due to COVID-19). The Department is reviewing compliance with federal, Commonwealth, and contract requirements through review of system demonstrations, staff interviews, demonstration of operational procedures, and meetings to discuss follow up to desk reviews of materials. The Department will issue required follow up items and corrective action for immediate action, if needed. Note that readiness reviews were in progress at the time of submission of this waiver renewal applications, and therefore results, problems, and corrective actions are not included.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** For the annual onsite reviews, of the quality-related domains reviewed for each MCO, all received full or substantial overall determinations of compliance.

- **Problems identified:** Concerns were identified for all MCOs across various elements, with the most common being in the Grievance System domain for four MCOs.

- **Corrective action (plan/provider level):** CAPs have been required specific to the problems identified in the various domains during annual onsite reviews. All CAPs were reviewed and accepted.

- **Program change (system-wide level):** None.

12. Performance Improvement projects [Required for MCO/PIHP]

- **Strategy:** DMS requires MCOs to implement PIPs to achieve improvement in priority areas. MCOs are expected to develop collaborative relationships with behavioral health agencies, community based organizations and health care delivery systems.

  The Department, EQRO, and MCOs have worked over the course of the program to evolve requirements for PIPs to work towards effective solutions to impact improvements in quality and access for enrollees. The Department requires each MCO to have active PIPs that are each completed in a period determined by the Department to allow information on the success of the project in the aggregate to produce new information on quality of care each year. The Department and the EQRO support the sharing of information and development of interventions for collaborative PIPs that all MCOs must implement as an opportunity to overcome barriers for a specific focus area.

- **Confirmation it was conducted as described:**

  X Yes

__ No. Please explain:

- **Summary of results:** MCOs participate in quarterly quality meetings or more frequent meetings with the Department to review progress in achieving the identified goals and targeted improvements for the PIP focus areas. The Department may request ad-hoc meetings as necessary. Prior to each quarterly meeting, MCOs must submit a status report detailing progress, successful strategies, and challenges in achieving improvements.

  Status reporting and results must be provided in compliance with federal regulations and with sufficient detail for the Department to evaluate reliability and validity of the data and the conclusions drawn. MCOs must also submit final reports that provide detailed information addressing all items, as applicable, that are outlined in the CMS Protocol for Performance Improvement Projects, PIP Review Worksheet.

  MCOs validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement.

  As an example, MCOs conducted a PIP related to prenatal smoking, for which improvements were shown in indicators measured (e.g., receipt of cessation intervention).

- **Problems identified:** While improvements were indicated for some areas, concerns with findings and ability to interpret improvement were noted for other areas (e.g., due to lack of baseline rates).

- **Corrective action (plan/provider level):** Corrective action was required of one MCO for which the credibility of results were questionable.

- **Program change (system-wide level):** None.

13. Performance measures [Required for MCO/PIHP]

- **Strategy:** MCOs are required to have a quality management and performance improvement approach that incorporates rigorous outcomes measurement against relevant targets and benchmarks. The Department specifies the required performance and outcomes measures that MCOs must address, including Health Care Effectiveness Data and Information Set (HEDIS™) measures and Kentucky-specific measures.

- Confirmation it was conducted as described:

  X Yes
  __ No. Please explain:

- **Summary of results:** MCOs must report activities to address performance measures in the QAPI Plan quarterly and in annual reports. MCOs must make comparisons across data for each measure by the Commonwealth's Medicaid geographic regions, eligibility category, race ethnicity, gender and age to the extent such information has been provided

by the Department. MCOs must consider social determinants of health into the process for analyzing data to support population health management. MCOs must submit a plan to the Department for initiatives and activities to address identified disparities.

MCOs collect and report HEDIS™ data annually, including the Final Auditor's Report issued by the NCQA certified audit organization and a copy of the interactive data submission system tool.

For each measure reported, MCOs must trend results from all previous years and include benchmark data and performance goals established for the reporting year, where applicable.

The Department's EQRO provides analysis of measurement and reports findings and recommendations for improvement for each MCO.

The Department's recent independent assessment also addresses review of performance measures.

- **Problems identified:** The Department's EQRO has provided recommendations for improvement for each MCO.

- **Corrective action (plan/provider level):** The Department provides input to the MCOs as to performance on each measure and any required corrective actions

- **Program change (system-wide level):** As previously discussed, the Department is implementing an increased focus on improving health outcomes for the enrollee population. The Quality Strategy has been updated to establish a process for addressing outcomes and social determinants of health. New MCO contract include extensive requirements for care management with required implementation of a population health management program with extensive focus on improving health outcomes. The Department is working to increase collaboration with and across the MCOs with a focus on enrollees and improved data to better understand challenge areas to address.

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

- **Strategy:** As discussed under network adequacy, this process takes place on a quarterly basis to include an analysis to address the access to care standards. EQRO studies include analyses of provider numbers and types.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Refer to section C.6 and C.9.

- **Problems identified:** C. 6. More detailed provider type definitions and reporting specifications are merited.

- **Corrective action (plan/provider level):** None.

- **Program change (system-wide level):** As noted above, the Department is also collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for contracts to begin January 1, 2021, including extensive changes to provider network reporting.

15. Profile utilization by provider caseload (looking for outliers)

- **Strategy:** The Department analyzes reports that focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and underutilization of services, and the development of user-defined reporting criteria and standards.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Overall, compliance review findings showed that most MCOs met compliance requirements, with few issues.

- **Problems identified:** The few issues identified were in expansion and/or changes in the network, provider program capacity, additional network provider requirements and emergency care, urgent care and post stabilization care.

- **Corrective action (plan/provider level):** The Department's EQRO issues recommendations in the relevant compliance review tool and MCOs responded with plans to address issues.

- **Program change (system-wide level):** As noted above, the Department is also collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for contracts to begin January 1, 2021, including extensive changes to provider network reporting.

16. Provider Self-report data

- **Strategy:** MCOs must conduct an annual survey of provider satisfaction with the quality of services and access to services. Information is reported to the Department. Additionally, the Department conducts annual provider forums.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** In 2019, an MCO had continued efforts to improve member satisfaction and provider dissatisfaction issues regarding their payments that influenced members' satisfaction. Another MCO also found this area to be an opportunity for improvement. The MCO implemented targeted-interventions such as one-on-one case management and disease management and distribution of provider Care Gap Reports by Quality Practice Advisors (QPAs), They also transitioned to a population health approach to member care.

- **Problems identified:** Issues were identified and addressed by two MCOs. One MCO worked to assess gaps and strategize about improvement and intervention plans for member and provider satisfaction. Another has implemented a population health program, including emphasis on empowering individuals to improve their health and engage in their healthcare. The MCO works with members and providers to help them navigate the healthcare system, transition from one care setting or level of care to another, and receive the care/services they need.

- **Corrective action (plan/provider level):** For CAHPS, one MCO found opportunities for improvement include ease of getting care, how well doctors communicate with members, customer service, and the overall rating of the health plan. The MCO identified barriers and interventions for measures below the QC national average and identified areas for improvement. Another MCO conducted "Secret Shopper" calls to providers to assess access/availability standards. The MCO monitored network adequacy to ensure members have access to care and continued to actively recruit providers into the provider network. Access/availability was also reported quarterly to the QI Committees for ongoing, monitoring, feedback and recommendations.

- **Program change (system-wide level):** None.

17. Test 24 hours/7 days a week PCP availability

- **Strategy:** The EQRO performs an annual review of primary care providers and selected specialists, dentists and behavioral health providers to assess availability and access to providers.

  Additionally, the Department requires MCOs to monitor provider compliance with access requirements and take corrective action for failure to comply.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** HEDIS 2019 Access and Availability measures examine the following: adults who receive preventive/ambulatory health care services, children and adolescents who access their primary care providers, annual dental visits, alcohol and other drug abuse or dependence treatment, access to prenatal and postpartum care services and use of first-line psychosocial care for children and adolescents on antipsychotics.

  Results are reported, analyzed, and feedback provided as described in Item C.13 above.

  For example, all five MCOs ranked above the national 75 th percentile for IET: Engagement of AOD Treatment: Total. There were four MCOs ranking at or above the national 50th percentile for IET: Initiation of AOD Treatment: Total and for APP. All five MCOs were below the 50 th national Medicaid percentile for PPC: Postpartum Care measure.

- **Problems identified:** Statewide rates related to access and availability showed mixed results for Kentucky Medicaid MCOs. The statewide average ranked at or above the Medicaid NCQA national 50th percentile for 9 of the 14 measures. Measures below the NCQA national 50th percentile included: ADV, PPC and AAP rates for all age groups 20-44, 45-64 and Total.

- **Corrective action (plan/provider level):** No corrective action plans were indicated. MCOs set target rates for improvement in the QAPI work plan.

- **Program change (system-wide level**): As previously discussed, the Department is implementing an increased focus on improving health outcomes for the enrollee population. The Quality Strategy has been updated to establish a process for addressing outcomes and social determinants of health. New MCO contract include extensive requirements for care management with required implementation of a population health management program with extensive focus on improving health outcomes. The Department is working to increase collaboration with and across the MCOs with a focus on enrollees and improved data to better understand challenge areas to address.

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

- **Strategy:** MCOs must have a comprehensive utilization management program that reviews services for medical necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. MCOs must report on utilization data quarterly, as well as, an annual utilization management program evaluation.

- **Confirmation it was conducted as described:**

  X Yes
  __ No. Please explain:

- **Summary of results:** Overall, compliance review findings showed that MCOs were compliant with utilization review requirements, with only a few problems identified.

- **Problems identified:** Problem areas for two MCOs were focused on adverse benefit determination related to requests for services and coverage denials.

- **Corrective action (plan/provider level):** The Department's EQRO issues recommendations in the relevant compliance review tool and each MCO responded with plans to address the compliance issue.

- **Program change (system-wide level):**
  As noted previously, the Department is collaborating extensively with MCOs to prepare a comprehensive reporting package in preparation for contracts to begin January 1, 2021, including utilization management reporting.

Section D: Cost-Effectiveness

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

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

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

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

Medicaid Eligibility Groups

	MEGS Across all Time Periods	**First Period**		**Second Period**	
		Start Date	**End Date**	**Start Date**	**End Date**
Actual Enrollment for the Time Period**	Children 18 and Under MCHIP Adults over 18 SSI Adults, SSI Children, and Foster Care Dual Medicare and Medicaid Former Foster Care ACA Expansion Adults	1/1/19	12/31/19	1/1/20	6/30/20
Enrollment Projections for the Time Period*		1/1/21	12/31/21	1/1/22	12/31/22
Enrollment Projections for the Time Period -		1/1/23	12/31/23	1/1/24	12/31/24
Enrollment Projections for the Time Period -		1/1/25	12/31/25		
	**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Services Included in the Waiver

State Plan Services				
Service Category	**State Plan Approved Services**	**1915(b)(3) Services**	**MCO Capitated Reimbursement**	**FFS services Impacted by MCO**
Inpatient Hospital	x		x	
Mental Health Facility Services	x		x	
Clinic Services	x		x	
Psychiatric Residential Treatment Facility	x		x	
Outpatient Hospital	x		x	
Medical Care and Any Other Type of Remedial Care	x		x	
Targeted Case Management	x		x	
Preventive	x		x	
Other Practitioners Services	x		x	
Other Laboratory and X-ray Services	x		x	
Physical Therapy	x		x	
Occupational Therapy	x		x	
DME, Medical Supplies, Prosthetics and Orthotics	x		x	
Primary Care	x		x	
Rehabilitative Services (non-school based)	x		x	
Rural Health Clinic	x		x	
Family Planning Services and Supplies	x		x	
Home Health Services and Supplies	x		x	
EPSDT	x		x	
Nurse Practitioner Services	x		x	
Hospice - Noninstitutional	x		x	
Ambulance	x		x	
Non-ER Transportation (stretcher ambulance)	x		x	
Pharmacy	x		x	
Medical Care and Any Other Type of Remedial Care	x		x	
Dental	x		x	
Physician	x		x	
Nurse Practitioner	x		x	
Speech, Hearing, and Language Services	x		x	
Emergency Hospital Services	x		x	
Private Duty Nursing Services	x		x	
ICF/IID	x		x	

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: __Steve Bechtel, CFO_____

c. Telephone Number: 502-564-4321, Ext. 2032

d. E-mail: _Steve.Bechtel@ky.gov _____

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

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

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

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

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

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

payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

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

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

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

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

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

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

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

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

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

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

_____

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

_____

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

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

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

_____

For Conversion or Renewal Waivers:

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

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

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

All member month projections were determined using an ARIMA time series regression. This incorporates recent historical growth and incorporates inflationary findings and future projected economic conditions. Member months were projected to grow based on recent trend and projected economic conditions.

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

No significant variance to report.

e. _**X**_ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: Calendar Year.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

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

There are no new services. Impact Plus has been removed.

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

All costs associated with the 1115 SUD Demonstration will be added to the 1915(b) costs to determine cost effectiveness for the 1915(b) waiver.

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

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

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

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

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

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*

Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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

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

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

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

2.____ 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: _____. Please document how that trend was calculated:

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: 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_____. 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 _____
D.____Other (please describe):

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

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

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

3. Explain any differences:

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

1.___ 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.

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

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ 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**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

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

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

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

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

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

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

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

costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

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

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

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: 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.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

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

3.___ 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.

- 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. _**X**_ [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: ___5.5%_____. Please document how that trend was calculated:

   A linear regression method to forecast and adjust for inflation and economic conditions.

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

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

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

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

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

(1) HIF was repealed by Congress. (2) Rate increase of 1.8%.

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.____ **X** Other (please describe):

HIF was repealed by Congress resulting in an adjustment not being necessary that occurred in past versions of cost effectiveness. The adjustment of 1.8% resulted from the state's decision to increase to the 50th percentile on the rate range from the 15th percentile.

Also, Directed Payments paid by MCOs processed outside the capitation rates (Inpatient Hospital discharge add-on up to average commercial rate and Ambulance per trip add-on) were not included in the R1/R2 actual costs data. Applied 26.4% additional program adjustment for P1.

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. _X__ **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._X__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._X_ 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._X__Other (please describe):

Inflation trend applied evenly across all MEGS to administration costs. Administrative expenditures are estimated to grow at an average annual rate of 2.0% through 2028. Source: page 13 https://www.cms.gov/files/document/2018-report.pdf.

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. **X** 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.

The cost increases between R2 and P1 are driven almost entirely, an increase in expected enrollment. Adjustments were made for inflation.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   Member months were projected to grow based on recent trend and projected economic conditions.

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**:

   HIF was repealed by Congress resulting in an adjustment not being necessary that occurred in past versions of cost effectiveness. In addition, an adjustment of 1.8% resulted from the state's decision to increase to the 50th percentile on the rate range from the 15th percentile.

   Adjustments were made for inflation.

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**:

   No significant variation is anticipated or noted in the provided spreadsheet template.

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.