

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

April, 2020

Table of Contents

Facesheet	3
Section A – Waiver Program Description	4
Part I: Program Overview	
Tribal Consultation	4
Program Description	4
Waiver Services	4
A. Statutory Authority	5
B. Delivery Systems	5
C. Restriction of Freedom-of-Choice	5
D. Populations Affected by Waiver	6
Part II: Access, Provider Capacity and Utilization Standards	
A. Timely Access Standards	7
B. Provider Capacity Standards	8
C. Utilization Standards	11
Part III: Quality	
A. Quality Standards and Contract Monitoring	12
B. Coordination and Continuity-of-Care Standards	13
Part IV: Program Operations	
A. Beneficiary Information	14
B. Individuals with Special Needs	14
Section B – Waiver Cost-Effectiveness and Efficiency	15

Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Maryland 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 programs** are *Mental Health Targeted Case Management: Care Coordination for Adults* and *Mental Health Targeted Case Management: Care Coordination for Children and Youth*.

Type of request. This is:

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

a request to amend an existing waiver, which modifies Section/Part _____

a renewal request

Section A is:

replaced in full

carried over with no changes

changes noted in **BOLD**.

Section B is:

replaced in full

changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning 10/01/2020 and ending 9/30/2025.

State Contact: The State contact person for this waiver is Rebecca Frechard and can be reached by telephone at (410) 767-1750, or fax at () _____, or e-mail at **Rebecca.Frechard@maryland.gov**.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. In November, 2010, the State appointed a designee of the Urban Indian Organization to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the Urban Indian Organization on an as needed basis to develop SPAs and regulations which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations. The State sent this waiver proposal to a representative from Maryland's Urban Indian Organization, Kerry Lessard, for review and comments on **May 1, 2020**.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

In 2014, CMS approved applications for Maryland's Mental Health Targeted Case Management (TCM) State Plan Amendments (SPA) for the adult population, as well as children and youth. These provide care coordination services to adults with Serious Mental Illness (SMI) and children and youth with Serious Emotional Disturbance (SED). Under the 1915(b)(4) authority, the State waived the freedom of choice of providers for case management services. **From Federal Fiscal Years 2015 through 2019** the program has served a combined **average of 5,805** participants per year, including approximately **1,485** children and youth, and **4,320** adults.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

This 1915(b)(4) waiver covers two services— Case Management Services for Individuals with Serious Mental Illness, and Mental Health Case Management: Care Coordination for Children and Youth.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

1915(b) (4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

- a. **Section 1902(a) (1) - Statewideness**
- b. **Section 1902(a) (10) (B) - Comparability of Services**
- c. **Section 1902(a) (23) - Freedom of Choice**
- d. **Other Sections of 1902 – (please specify)**

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

the same as stipulated in the State Plan
 is different than stipulated in the State Plan (please describe)

2. **Procurement.** The State will select the contractor in the following manner:

Competitive procurement
 Open cooperative procurement
 Sole source procurement
 Other (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations.**

Beneficiaries will be limited to a single provider in their service area.
 Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The programs **are** implemented statewide. Each **Local Behavioral Health Authority (LBHA)**, the local health authority for mental health and or substance use disorder, acting as the Department's designee, will complete a competitive procurement process for their **jurisdiction**, resulting in contracts with one or more service provider(s). Depending on an individual's service area, they may have a single provider to which they are limited, or multiple providers from which to choose.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There will be no differences in the state standards that are applied under this waiver and those detailed in the State Plan coverage and reimbursement documents.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

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

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Title XXI CHIP Children

The TCM programs must serve all individuals who meet the functional and financial eligibility requirements. The Adult TCM program serves those 18 years and older with a SMI diagnosis and meets medical necessity criteria for the program. The TCM program for children and youth must serve those 21 years of age and younger who have similarly met the criteria for participation, including SED or SMI. All individuals who are determined eligible for Medical Assistance coverage under the State Plan, will be financially eligible for TCM.

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program
- American Indians/Alaskan Natives
- Special Needs Children (State Defined). Please provide this definition.
- Individuals receiving retroactive eligibility
- Other (Please define):

Individuals who do not meet the medical, technical, or financial criteria are excluded from participation. Individuals participating in the Health Home program are excluded from participation in TCM as well.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

Requirements for timely access are monitored by the LBHA, the same entity that conducts the selective procurement. The Behavioral Health Administration (BHA) delegates provider oversight to LBHAs to ensure provider compliance is maintained.

For adult participants, State regulations require TCM providers to complete an assessment within 20 days of an individual receiving authorization for TCM services, followed by the completion of an initial plan of care within 10 days of the assessment.

The LBHA schedules an annual site visit which includes an audit of the documentation for each TCM program in their jurisdiction. The LBHA reviews policies and procedures, staff credentials and backgrounds, consumer satisfaction and chart documentation to assure the TCM providers meet the standards set forth in COMAR 10.09.45 for mental health case management for adults. If they do not meet the regulatory standards, a corrective action plan (CAP) is required from the provider and is submitted to the local authority. After CAPs are reviewed and approved, the LBHA follows up at subsequent annual site visits or in the interim. The state regulation noted above with regard to completion of an assessment and initial care plan for adults are specifically addressed in the Audit Summary Report tool used by the LBHA for the purposes of monitoring compliance with the state regulations.

For child and youth participants, State regulations require TCM providers to schedule a meeting with the child and family team within 72 hours of enrollment in the program, and complete an initial meeting within 30 days to develop a plan of care.

A review of a statistically appropriate set of casefiles is conducted during the annual monitoring visits that compares the provider's performance against the standards set forth in state regulations for both TCM programs. The purpose of this monitoring process is to assure the standards are met. In the event that the standards are not met, the provider is required to submit a CAP to bring the program into compliance. The standards of 72 hours to schedule a child and family

team meeting and to complete a plan of care for children and youth are part of the monitoring tool used by LBHAs when reviewing child and youth programs.

The Hilltop Institute completed an Independent Assessment (IA) of Maryland's 1915(b)(4) waiver for TCM in April 2020 and found that annual audit visits provide ongoing assurance that individuals are receiving services in a timely manner and in accordance with state regulations.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

The need for corrective action plans (CAP) is determined by the results of conducted site visits. The LBHA uses the identified statewide forms to monitor adherence to each provision of the COMAR regulation. If any deficits are noted during a site visit, a CAP for the provider is initiated. The IA found that noncompliance with the timely access standard was a common reason for issuing CAPs. Providers are given a deadline to develop CAPs. The provider submits the CAP to the LBHA, who reviews and determines if an interim site visit is required or if the plan appropriately addresses all deficits without requiring a visit prior to the next annual site visit.

Hilltop recommends in their assessment that data be collected from each LBHA regarding the results of the annual provider auditing process in order to analyze trends in the noted deficiencies for access to care and required CAPs to inform targeted technical assistance and uniform corrective action at the state level.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

Each LBHA, acting as the Department's designee, completes a competitive procurement process for its jurisdiction. The number of providers selected is dependent upon the population and needs of the region. The IA found that LBHAs reported different approaches to assessing and addressing the capacity needs of their respective jurisdictions, but there were two trends in how needs were assessed. These included analyzing data to estimate capacity needs based on past utilization and building

specific language into provider contracts that require expansion to accommodate increases in service utilization. TCM providers must demonstrate their capacity to serve the region's population during the bid process in order to be selected. Urban areas such as Baltimore City may include more than one TCM provider to ensure adequate coverage. **On the rural Eastern Shore, a five county consortium selects the vendor through a single bidding process. In other rural areas of the State, jurisdictions have partnered to conduct joint solicitation for providers in a single process. It should be noted that a number of TCM providers are selected by multiple jurisdictions. Each LBHA procures providers that are able to serve both adults and children and youth, although separate provider organizations may be selected for each age group. Over the past three years, 29 Children and Youth TCM providers and 36 Adult TCM providers have been active across 24 jurisdictions, including Baltimore City and Baltimore County. Within the Children and Youth program, it should be noted that several providers have offices in a number of jurisdictions where they have been selectively contracted. This is particularly true in rural areas of the state.**

The LBHA selects a mental health case management provider through a competitive process, once every five years. The selected case management program is designated by the LBHA and subject to the requirements set forth COMAR 10.09.45 Mental Health Case Management: Care Coordination for Adults and 10.09.90 Mental Health Case Management: Care Coordination for Children and Youth. The BHA has created a template for the Request for Proposals (RFP) for the local authorities to use. The LBHA advertises the procurement including expectations and deadlines for submission of the proposals, offers a pre-bidders conference, convenes a review committee in order to select the provider, and following selection, announces the award. The LBHA sends BHA a letter identifying the selected case management program(s). When the provider submits an application to Medicaid for a Medicaid provider number, the provider must submit the CSA/LBHA letter of support/selection in order to be enrolled as a Mental Health Case Management provider. Providers are required to have a separate MA and NPI number for each service location. The provider is also required to submit a letter of attestation stating their commitment to adhere to consumer choice and to other relevant regulations regarding documentation governed by Medicaid. Once approval by Medicaid is obtained, the selected provider must register with the State's Administrative Service Organization (ASO) in order to obtain authorizations and bill for services rendered.

The IA found that LBHAs value participants' rights to have a choice of providers. It was recommended that the State work directly with LBHAs to help them award contracts to more than one provider through efforts such as advertising and sharing information about RFPs with stakeholders, providers, and community groups. This should increase the number of quality responses during the solicitation process and the probability that more than one contract could be awarded for more choice.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

The State evaluates the distribution of providers on a regular basis through its statutorily mandated local jurisdictional planning process. Through this process, the local designated authorities describe their behavioral health planning, management and monitoring efforts to ensure access to and availability of quality services and to promote comprehensive and cost-effective service delivery and desired outcomes for individuals and families. Jurisdictions are required to submit an annual plan for the upcoming fiscal period as a condition of funding, including a summary of highlights and accomplishments from the prior year. The plans must address the needs of individuals and minority populations delineated by the Maryland Department of Health (MDH) /Behavioral Health Administration (BHA). Plans must describe how local behavioral health entities plan, develop, and manage the full range of prevention, intervention, treatment and recovery services including discussions that identify issues and gaps, as well as initiatives in the jurisdictions to address those gaps. As a component of this local planning process, the local authorities are able to provide comprehensive three year data sets on a wide number of services, including TCM covered by this waiver, using the Administrative Services Organization (ASO) platform to download data reports of consumer counts and claims/service expenditures using standardized data templates. The TCM specific data set includes the following: individual utilization numbers, total costs, and average cost per individual served. This three year data trend is provided to jurisdictions both for the jurisdiction itself, and in comparison of the jurisdiction against the statewide average for TCM. LBHAs are required to compare their data with the statewide average in determining the adequacy of their program and the need to expand the number or capacity of providers in their selective contracting program. The state-issued guidelines for the local plans require jurisdictions who fall below the statewide average to provide analysis about local factors that may account for lower than average utilization and to provide strategies for addressing improved utilization in the upcoming year.

BHA, in turn, compiles and aggregates the data from each jurisdiction's response to these specific plan requirements to identify underperforming jurisdictions. These aggregated data from the local planning inputs are then used to drive coordinated state remediation and technical assistance for underperforming jurisdictions.

Each LBHA completes a procurement process at least once every five years. The State reviews on an annual basis through the BHA planning process described above, the distribution of enrollees and applicants to TCM and may revise the number of TCM providers accordingly. The State monitors provider capacity and may solicit additional TCM providers more frequently if needed. The LBHA monitors service delivery, with oversight by the BHA, to ensure participants receive services in a timely manner on an

ongoing basis. **The BHA, when possible, will participate with the LBHA on the annual site visit. Following each visit, the BHA will issue the provider a certificate of approval that is valid for a year.**

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

The State has established utilization standards in the State Plan Amendment for each TCM program. Participants are pre-authorized by the State's ASO to receive TCM services at a specified level of intensity. Targeted Case Management services for adults include two levels of intensity. Participants in Level I receive a minimum of 30 minutes of face to face contact monthly, and a maximum of three hours. Level II participants receive a minimum of one hour of face to face contact monthly, and a maximum of 10 hours.

Services for children and youth mirror the first two levels, and include an additional third level of intensity, with a minimum of 90 minutes of face to face contact monthly and a maximum of 15 hours. Maximum service limits may be exceeded dependent upon ASO review and authorization.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

Mental Health Case Management services are available to any individual who is enrolled in Medicaid and meets the technical and financial criteria outlined in COMAR 10.09.45 or COMAR 10.09.90. The IA found that service utilization data indicated a significant growth in the TCM program between CY 2014 and CY 2018. The process of competitively selecting TCM providers allowed for an 83% growth in utilization. The provider uses the information from referral, referral documentation, and the initial assessment to determine the level of care that is needed, either General or Intensive for adults, or General, Moderate, or Intensive for children and youth. The provider then submits the authorization request to the ASO who reviews the medical necessity criteria (MNC) and approves the request for the level of care. The provider reassesses the need every 6 months and submits an authorization request for concurrent review. The level of care (LOC) has standards for the number of monthly encounters and lengths of time spent with the individual to meet their needs. Adult participants in the General LOC receive 2 encounters per month and participants in the Intensive LOC receive 5 encounters per month. Children and youth participants in the General LOC receive 12 encounters per month, participants in the Moderate LOC receive 30 encounters per month, and participants in the Intensive LOC receive 60 encounters per month.

As the State's designee, the ASO approves and monitors participants' plans of care which **detail the medical necessity for the authorization at a particular level of service. The State in turn monitors ASO performance annually through a casefile review process that samples casefiles from each of the TCM programs operating under this waiver to assure that medical necessity criteria are appropriately applied. The ASO provides training to its staff to assure that the clinical criteria are applied in a consistent manner.**

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

In addition to the ASO review noted above, service utilization for TCM is monitored by the ASO through concurrent authorization review, post payment review, and/or provider audits. If utilization falls below the level of care authorized over the course of a month based on the individual's plan of care, a corrective action plan will be required by the provider. In the event the ASO does not adequately authorize services based on the established utilization standards, it will be required to take corrective action to remedy its performance.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.
 - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):
 - i. Regularly monitor(s) contracted providers to determine compliance with the State's quality standards for the selective contracting program.
 - ii. Take(s) corrective action if there is a failure to comply.

All providers must meet service delivery requirements specified in the Code of Maryland Regulations 10.09.45 for adult case management services, and 10.09.90 for children and youth case management services.

The LBHAs, with BHA oversight, **are** responsible for regularly monitoring selected providers against the COMAR quality standards and take action in the case of failure to comply. This includes a corrective action plan (CAP) that must be completed satisfactorily within an allotted period of time.

The LBHA schedules an annual site visit for each TCM program in their jurisdiction. The LBHA reviews Policies and procedures, staff credentials and

backgrounds, consumer satisfaction and charts to assure they meet COMAR 10.09.45 standards for mental health case management for adults and COMAR 10.09.90 standards for mental health case management for children and youth. If they do not meet the regulatory standards, the provider is required to submit a CAP to the local authority. CAPs are reviewed and approved, and the LBHA follows up at subsequent site visits, annually or at an interim time.

The need for a CAP is determined by the outcome of the site visit and review of required documentation. The LBHA uses statewide forms that follow each aspect of the COMAR regulation. If any significant deficits are noted during chart review, the program will be required to submit a CAP.

Providers are given a deadline for completion and submission of CAPs to the LBHA. The LBHA reviews the CAP and determines if an interim site visit is required or if the plan appropriately addresses all deficiencies without requiring a visit prior to the next annual site visit.

2. Describe the State's contract monitoring process specific to the selective contracting program.
 - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):
 - i. Regularly monitor(s) contracted providers to determine compliance with the contractual requirements of the selective contracting program.
 - ii. Take(s) corrective action if there is a failure to comply.

The site visit procedure has been described above. The contracting LBHA, in concert with BHA, schedules an annual site visit and selects a random sample of participant case files for review against established criteria. In the event that it is determined that the provider has not adequately met the standards, a CAP is required and subsequent review initiated. The State requires a CAP for a provider that fails to meet contractual/provider agreement requirements. A total of 12 CAPs were required from 2016 through 2018 for Adult TCM providers. Five of the CAPs have currently been resolved. A total of 15 CAPs were required from 2016 through 2018 for Children and Youth TCM providers. Two of the CAPs have currently been resolved and one was reopened. In the event a provider fails to meet contractual requirements under the CAP, the State will take action based on procurement rules.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The selective contracting program improves quality and continuity of care by ensuring that only the most qualified and capable providers are enrolled to deliver case

management services to the TCM population. Individuals with SMI and SED are an especially vulnerable population, and it is vital that case management providers are carefully reviewed and held to a particularly high standard. The selective contracting process allows the state to enroll only providers who meet this standard, and maintain regular oversight through the role of the LBHAs. The process will ensure adequate coverage, high-quality services, and regular oversight and accountability among providers. **The IA found that ongoing implementation of selective contracting of TCM providers will continue to allow the state to identify qualified providers with extensive knowledge of local service systems, helping stabilize individuals to lower levels of care and creating cost savings for the state.**

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Upon approval for TCM services, the LBHA provides applicants with information regarding the TCM provider(s) in their region. The providers identified through the competitive solicitation are also responsible for providing required information to enrollees.

B. Individuals with Special Needs.

— The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Mental Health Targeted Case Management Services aim to facilitate community-based supports and services for individuals with SMI and SED, in order to avoid the need for a residential level of care. The competitive procurement process proposed will ensure that the State will enroll only the most high-quality providers with full capacity to meet the coverage needs of the region. Additionally, procurement and oversight by the LBHAs ensures that those procuring and monitoring these services are extremely familiar with the needs and resources of the local communities. As a result, the State anticipates quality of care will improve, assisting more participants in successfully avoiding the need for **more intensive** levels of care, increasingly stabilizing to lower levels of case management intensity, and ultimately lowering costs to the State. **The IA found that there has been no negative impact on the cost of services to the**

state when highly qualified providers with extensive knowledge of local service systems are selectively contracted.

Cost savings can be seen through savings in residential treatment costs, as well as savings in the Targeted Case Management program itself. **The cost of total paid claims for residential treatment decreased an average of 6.7% from federal fiscal year 2015 through 2019. Even though the cost of residential treatment decreased, enrollment for Maryland Medicaid increased an average of 8% from federal fiscal years 2015 through 2019. Although the IA found that the frequency of emergency department (ED) visits was higher than the general Medicaid population, the frequency of these incidents decreased for adult TCM participants from CY 2014 to CY 2018.**

The projections below are based on **the difference between the pre-waiver cost calculated using total paid claims for federal fiscal year 2014 (\$7,199,765.65), the projected waiver cost calculated using the projected total paid claims for federal fiscal year 2019, and the average percent increase in total paid claims found for the TCM program for federal fiscal years 2013 through 2019 (19.10%). The total paid claims for each fiscal year were increased by 19.10% and the difference was calculated. The difference between the costs for the TCM program without selective contracting and with selective contracting would save the State an average of \$725,009.99 per year.**

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 10/01/2020 to 09/30/2021

Trend rate from current expenditures (or historical figures): 19.10 %

Projected pre-waiver cost	<u>\$24,473,759.66</u>
Projected Waiver cost	<u>\$23,940,049.97</u>
Difference:	<u>\$533,709.69</u>

Year 2 from: 10/01/2021 to 09/30/2022

Trend rate from current expenditures (or historical figures): 19.10 %

Projected pre-waiver cost	<u>\$29,148,247.79</u>
Projected Waiver cost	<u>\$28,512,599.52</u>
Difference:	<u>\$635,648.24</u>

Year 3 (if applicable) from: 10/01/2022 to 09/30/2023

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>\$34,715,563.08</u>
Projected Waiver cost	<u>\$33,958,506.03</u>
Difference:	<u>\$757,057.05</u>

Year 4 (if applicable) from: 10/01/2023 to 09/30/2024

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>\$41,346,235.63</u>
Projected Waiver cost	<u>\$40,444,580.68</u>
Difference:	<u>\$901,654.95</u>

Year 5 (if applicable) from: **10/01/2024** to **09/30/2025**

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>\$49,243,366.64</u>
Projected Waiver cost	<u>\$48,169,495.59</u>
Difference:	<u>\$1,073,871.05</u>