Application for

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

January 2017

v1.0

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Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Montana 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 Montana Autism Evaluation and Service Review Waiver. (List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_X_ 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 __3__ years beginning _January 1, 2017_____and ending _December 31, 2019_____.

State Contact: The State contact person for this waiver is Catherine Murphy and can be reached by telephone at (406) 444-1716, or fax at (406) 444-0230, or e-mail at catmurphy@mt.gov. (List for each program)

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.

The State of Montana sent a Tribal Consultation notice to each Tribe, Urban Indian Center, and Indian Health Service in Montana on September 7, 2016 to invite comment on the waiver. The State provided information on the programs and direction on how to make comments, suggestions, or request more information regarding the waiver. The comment period closed on October 6, 2016. The State did not receive comments.

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.

The purpose of the 1915(b)(4) waiver is to engage in selective contracting with a sole source to provide evaluation services to determine eligibility for, and prior authorization of, services for a newly proposed Medicaid State Plan service. The contractor will provide two types of evaluation services: diagnostic evaluation services and comprehensive evaluation services for Montana Medicaid members under the age of 21 years and either believed likely of having, or diagnosed with, autism spectrum disorder (ASD) or related condition. The type of evaluation a member receives is based upon information received during the referral and intake process. The contractor will also conduct reviews for prior authorization of services based on medical necessity criteria.

A comprehensive evaluation confirms a member's diagnosis of ASD or related condition made by a qualified professional, and makes recommendations for autism related and other State Plan services to meet the member's needs. A comprehensive evaluation includes:

A. Assessment of the member's degree of severity of ASD core features, as well as other areas of functional development, including cognition, learning and play, social/personal interaction, verbal and non-verbal communication, adaptive, self-help, behavioral, self-regulation and motor development;
B. Collection, review and incorporation of the diagnosis and other related assessment information from other qualified professionals, including family members, child care providers, medical professionals, therapists, licensed school personnel or mental health professionals into the evaluation;
C. Identification of current Medicaid and non-Medicaid funded services the member is receiving and integration of those services into recommendations;
D. Identification of, and referral to, needed Medicaid and other publicly funded services;
E. Assessment of caregiver/parent training needed;

F. Collection of medical information from a licensed physician, physician assistant or advanced practice registered nurse; and
G. A Vineland-II Adaptive Behavior Scales assessment for members age 3 years or older
H. , or a Temperament and Atypical Behavior Scale (TABS) assessment for members under the age of 3 years.

A diagnostic evaluation determines whether or not a member referred for evaluation, who has not yet been diagnosed with ASD by a qualified professional, meets the diagnostic criteria for ASD or related condition. A diagnostic evaluation includes all components of a comprehensive evaluation, plus an Autism Diagnostic Observation Schedule (ADOS).

The sole source contractor must complete a medical necessity review every 6 months and periodically (at least every 3 years) update individualized assessments which are used to determine continued eligibility to receive the treatment plan, implementation guidance, or intensive treatment. The medical necessity review is completed based on the level of the following:

A. The Board Certified Behavior Analyst (BCBA) submits documentation to the contractor at least 21 calendar days prior to the 6 month expiration date;
B. The BCBA documentation shows an increase in skill acquisition on outcomes;
C. Member continues to meet medical necessity criteria;
D. A new provider or treatment modality may be chosen for one 6 month timeframe if a member does not have documented progress over the previous 6 months; and
E. A member who does not have documented progress after 12 consecutive months must be discharged from services.

Individualized assessments are completed at least every 3 years to assess adaptive behaviors as a component of the medical necessity criteria review.

With the exception of child/adolescent psychiatrist or pediatrician, the contractor is required to ensure independent diagnosis and recommendations by prohibiting evaluation team members from engaging in the delivery of services which might otherwise be offered by the contractor's evaluation team members. This process is intended to ensure evaluation team have no conflict of interest when making recommendations.

Waiver Services:

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

a. Diagnostic Evaluation
b. Comprehensive Evaluation
c. Utilization review/Medical Necessity Review
d. Updated Vineland II

A. Statutory Authority

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

   _X_ **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._X__**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
   _X__ is different than stipulated in the State Plan (please describe)

   Payment will be based on rates agreed upon through the competitive procurement process.

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

   _X_ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   ___ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   _X_ 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 waiver program will be implemented statewide with a single provider (contractor) delivering diagnostic and/or comprehensive evaluation services for the purpose of determining the type and level of service a member is eligible to receive. The contractor

will conduct evaluation services in at least 8 cities, strategically identified throughout the state to ensure availability of evaluation services to all eligible Montanans. The cities identified are Glasgow, Miles City, Great Falls, Billings, Helena, Bozeman, Missoula, and Kalispell.

The same contractor will be responsible for medical necessity reviews and periodic assessment of adaptive behaviors to determine ongoing treatment eligibility and needs based on medical necessity criteria. The periodic assessment of adaptive behaviors will occur in the same 8 cities identified for diagnostic and comprehensive evaluations. Medical necessity reviews are conducted via desk review.

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.

The contractor will be required to comply with State standards for reimbursement, quality, and utilization.

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:

_X__Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
___ Blind/Disabled Adults and Related Populations
_X__Blind/Disabled Children and Related Populations
___ Aged and Related Populations
_X__Foster Care Children
_X__Title XXI CHIP Children

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
_X__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):

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?

The contractor will be required to conduct, and submit written reports of, comprehensive and diagnostic evaluations within 30 calendar days of referral date. The contractor will be required to enter care spans within 5 business days of the completed comprehensive evaluation.

In order to assure reasonable accessibility to comprehensive and diagnostic evaluations, the contractor will be required to conduct evaluations in, or within a reasonable distance of, at least 8 identified cities in the state of Montana, strategically identified throughout the state to ensure accessibility of evaluation services to all eligible Montanans. The cities identified are Glasgow, Miles City, Great Falls, Billings, Helena, Bozeman, Missoula, and Kalispell. Montana is a rural state of over 147,000 square miles. Cities for evaluation sites were selected to assure evaluations are available within a reasonable distance of Medicaid enrollees. Members may also request travel reimbursement as identified in the State Plan Medicaid services via the Medicaid Non-Emergency Medical Transportation benefit.

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?

In addition to entering information into MMIS, the State Medicaid billing system, the contractor will be required to maintain a Health Insurance Portability and Accountaibuility Act-compliant database accessible to the State, including all pertinent information by which to measure timely access to eligible services. A representative sample size will be reviewed to determine the percentage of evaluations that occurred in a timely manner, within 30 days from the date of referral. The State proposes to conduct a formal review at least annually, but may audit data more frequently.

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 State anticipates using a pay-for-performance contract, meaning failure of the contractor to provide timely services may result in a decrease in payment, or even contract termination for systemic deficiencies. Referral and evaluation date data will be reviewed as part of the monthly invoicing process. The same process will be used to verify timely utilization review. The amount the contractor will be paid will be based on their compliance with timely delivery of evaluation services as identified in the contract.

Should Medicaid beneficiaries be unable to access the contracted service in a timely fashion due to contractor limitations, the contractor shall be required to remedy the situation.

Further, the State has a robust quality assurance system whereby State staff monitor compliance with requirements, and identify and follow up on deficiencies. Deficiencies and remediations are documented on a Quality Assurance Observation Sheet.

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.

Through the Request For Proposals (RFP) process, the potential contractor has identified professionals for each of the required positions necessary to form comprehensive evaluation teams for each of the 8 identified cities across the state. The State does not restrict these professionals to only provide evaluation services within their own geographical area; thus, the contractor has the flexibility to use their professional staff at any clinic site in the state to assure sufficient capacity.

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.

Currently, there are three contractors providing evaluation and diagnosis services for the Children's Autism Waiver operated through the Developmental Disabilities Program. This service is available for children up to the age of 5. In State Fiscal Year (SFY) 2016, which was July 1, 2015 through June 30, 2016, invoicing was submitted for 176 evaluations across 5 geographical regions. The number of evaluations invoiced in SFY 2015 was 169; and for SFY 2014, the number of evaluations was 149. Based on the number of individuals, age birth to 21 years enrolled in Medicaid in Montana, and the Centers for Disease Control and Prevention estimate of 1-in-68 individuals meeting the diagnostic criteria for ASD, the State estimates approximately 279 children in year 1, and 117 children in year 2 will request comprehensive or diagnostic evaluation services under this proposed waiver. The State estimates there will be approximately 117 additional recipients in year 3. The potential contractor has identified professional staff needed to provide comprehensive and diagnostic evaluation services, with multiple professional staff identified for more populated areas of the state.

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.

Through the RFP process, the State requires the contractor to have comprehensive evaluation teams available in each of the 8 strategically located cities across Montana to ensure evaluations are completed within 30 days of referral. The contractor is further required to maintain a database which includes date of referral, date of evaluation, evaluation team members, results and recommendations. The State will utilize information from the database to evaluate the number of timely evaluations by comprehensive teams as compared to the number of referrals for each of the 8 identified cities.

Evaluation teams must consist of:

A. A child/adolescent psychiatrist or pediatrician;
B. A BCBA, psychologist, licensed clinical professional counselor (LCPC), or licensed clinical social worker (LCSW); and
C. At least 2 of the following professions: speech therapist, occupational therapist; and/or physical therapist.
D. Credentialed professionals qualified to administer the ADOS, Vineland-II, and the TABS.

The State will review a statistically valid sample of evaluations to assure the required professions are participating. Evaluations will occur at least annually.

The medical necessity review is a desk review. The State requires medical necessity reviews to occur at 6 month intervals, with information submitted to the contractor to conduct the review at least 21 calendar days prior to the 6 month expiration date. The contractor must complete the review and take appropriate action prior to the expiration date to assure no lapse in service for those members continuing to meet the medical necessity criteria. This will be monitored through the invoicing process.

C. Utilization Standards

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

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?

   The contractor will serve 100% of eligible beneficiaries referred for evaluation services and will also conduct medical necessity review to determine eligibility to receive treatment plan, implementation guidance, or intensive treatment.

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.

A. The State will require remediation from the contractor if there is less than 85% accuracy in determining if a referred individual qualifies for evaluation services based on age and Medicaid status.
B. The State will require remediation from the contractor if less than 85% of eligible individuals who have not yet been diagnosed with ASD, as identified through the intake and information gathering process, do not receive a diagnostic evaluation.
C. The State will require remediation from the contractor if less than 85% of eligible individuals who have a diagnosis of ASD, as identified through the intake and information gathering process, do not receive a comprehensive evaluation.
D. The contractor will determine with at least 85% accuracy that a member is eligible for, or eligible to continue receiving, a treatment plan and implementation guidance.
E. The contractor will determine with at least 85% accuracy that a member is eligible for, or eligible to continue receiving, intensive treatment.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

A. The State will require remediation from the contractor if there is less than 85% accuracy in determining if a referred individual qualifies for evaluation services based on age and Medicaid status.
B. The State will require remediation from the contractor if less than 85% of eligible individuals who have not yet been diagnosed with ASD as identified through the intake and information gathering process do not receive a diagnostic evaluation.
C. The State will require remediation from the contractor if less than 85% of eligible individuals who have a diagnosis of ASD as identified through the intake and information gathering process do not receive a comprehensive evaluation.
D. The contractor will determine with at least 85% accuracy that a member is eligible for, or eligible to continue receiving, a treatment plan and implementation guidance.
E. The contractor will determine with at least 85% accuracy that a member is eligible for, or eligible to continue receiving intensive treatment.

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) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Random representative samples of 4 populations will be generated:

- Members authorized to receive treatment plan and implementation guidance services as a result of the comprehensive evaluation;
- Members authorized to continue receiving treatment plan and implementation guidance services as a result of the utilization review based on medical necessity criteria;
- Members authorized to receive intensive treatment services as a result of the comprehensive evaluation; and
- Members authorized to continue receiving intensive treatment services as a result of the utilization review based on medical necessity criteria.

During the first year of the contract, the State will monitor the contractor two times. During the second and subsequent years, monitoring will occur annually for services delivered through the twelfth month of each contract year. The State expects the contractor to meet quality standards for each of the 4 populations identified.

ii. Take(s) corrective action if there is a failure to comply.

A Quality Assurance Observation Sheet (QAOS) will be generated for any deficiencies identified. The contractor will be required to identify and implement an approved remediation plan. Failure to meet identified standards may result in contract termination.

2. Describe the State's contract monitoring process specific to the selective contracting program.

A. The State expects 100% of comprehensive and diagnostic evaluations will be conducted, including submission of written reports to be conducted within 30 calendar days from the date of referral. Evaluations completed within 31-45 calendar days will be reimbursed at 80% of the agreed upon amount for timely evaluations; completion within 46-60 calendar days will result in reimbursement at 60%and those evaluations exceeding 60 calendar days will be reimbursed at 50% of the agreed upon reimbursement amount.
B. The State expects the contractor to enter 100% of care spans and service authorizations into the MMIS system within 5 busineess days of completing the comprehensive evaluation.
C. The contractor must update the service authorization in the MMIS system within 1 business day of receipt of provider identification.
D. When presented with a request for additional services above initial limits, the contractor must make a determination based on criteria identified by the State within 5 business days of the date of request.
E. The contractor will notify legal representatives and update the service authorization within 3 additional working days.

F. The contractor is required to review documentation from providers to determine need for continuation of autism services based on both medical necessity and outcome progress at 6 month intervals.
G. For Medicaid members continuing to meet medical necessity and outcome progress criteria, service authorizations will be entered into the MMIS system in a timely fashion to ensure no lapse in service.

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) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

For the first year of the contract:

- The State will monitor item A. beginning in the month the first invoice for reimbursement is submitted, and monthly thereafter with the submission of each monthly invoice.
- Items B. and C. will be monitored for compliance beginning after the contractor has submitted invoicing for the third month of service, and quarterly thereafter.
- Items D., E., F., and G. will be monitored after the contractor has submitted invoices for the sixth month of services, and again after invoices have been submitted for the twelfth month.
- In both cases, a randomly generated representative sample for each service invoiced as noted above will be reviewed for compliance.

For the second and subsequent years of the contract:

- Item A. will continue to be monitored monthly.
- Items B. through G. will be monitored annually, following the submission of invoicing for the twelfth month of service by the contractor.

ii. Take(s) corrective action if there is a failure to comply.

Failure to meet the requirement for timely comprehensive and diagnostic evaluations, including written report, result in reduced payment as identified in Part III, A., 1., A. A QAOS will be generated for any deficiencies identified. The contractor will be required to identify and implement an approved remediation plan. Failure to meet identified standards may result in contract termination.

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 services to be delivered by this selective contract are not to replace or supplement any services or coordination that eligible Medicaid beneficiaries currently receive. The contractor is required to prohibit evaluation team members, with the exception of child/adolescent psychiatrists or pediatricians, from engaging in the delivery of autism State Plan services. This assures coordination and continuity of care is not negatively impacted. Additionally, regardless of medical necessity criteria for ASD related Medicaid services, the contractor will make recommendations for any other needed Medicaid State Plan or publicly funded service.

Part IV: Program Operations

A. Beneficiary Information

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

In addition to updating the Montana Medicaid Member Guide, information will be placed on the providers' page and member information page of the State's Department of Public Health and Human Services website. Information will also be distributed in a variety of formats to potential referral sources, stakeholders, and interested parties such as current contracted providers of services to individuals with intellectual/developmental disabilities, Montana's parent and information center for families of children with disabilities and special health care needs, and the Montana Council on Developmental Disabilities.

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.

The State applied currently approved rates and estimates of allowable hours needed to determine the cost of comparable services to project the pre-waiver cost. The projected waiver cost was determined using the accepted cost proposal through the competitive proposal process. No trend rate from current expenditures or historical figures is available as the services are not currently provided.

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

Year 1 from: 01/01/2017 to 12/31/2017

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

Projected pre-waiver cost _$778,410_____
Projected Waiver cost _$744,021_____
Difference: _$ 34,389_____

Year 2 from: 01/01/2018 to 12/31/2018

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

Projected pre-waiver cost _$452,907_____
Projected Waiver cost _$423,006_____
Difference: _$ 29,901_____

Year 3 (if applicable) from: _01/01/2019 to 12/31/2019_
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost _$452,907_____
Projected Waiver cost _$442,311_____
Difference: _$ 10,596_____

Year 4 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 5 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____