

**North Dakota  
Section 1915(b) Waiver Renewal  
Proposal For  
MCO Program:**

**Waiver for Managed Care Enrollment of Medicaid  
Expansion of New Adult Group.**

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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 North Dakota (ND) requests a waiver 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 Waiver for Managed Care Enrollment of the Medicaid Expansion of New Adult Group.*

**Type of request.** This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part \_\_\_\_\_
  - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
  - Document is replaced in full, with changes highlighted
- 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 is requested for a period of 2 years; effective January 1, 2020 and ending December 31, 2021.*

**State Contact:** The State contact person for this waiver is Stephanie Waloch and can be reached by telephone at (701) 328.1705, or fax at (701) 328.1544, or e-mail at [swaloch@nd.gov](mailto:swaloch@nd.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.*

*All Federally recognized tribes in the State of ND have been notified of this waiver renewal and have had the opportunity to review and comment on the waiver proposal pursuant to the process approved in the Medicaid State plan.*

*The notice of the 1915(b) Waiver renewal and a request for comment was sent on the July 1, 2019 Tribal Consultation letter (refer to Attachment A). Also, the Department met with representatives from ND Tribal Health Services, Indian Health Services, and ND Affairs Commission about the 1915(b) Waiver renewal with the basic components reviewed. Tribal Members were supportive, and no concerns noted at the August 20, 2019 Department of Human Services (DHS) Tribal Consultation meeting (refer to Attachment B).*

*Public notice of the 1915(b) Waiver renewal and a request for comment was posted on August 19, 2019 (refer to Attachment C). No input was received in response to the August 19, 2019 public notice. In addition, the Department presented information (refer to Attachment D) and reviewed the basic components of the 1915(b) Waiver renewal at the Medicaid Medical Advisory Committee. Committee members and individuals in attendance were supportive and no concerns noted at the August 29, 2019 meeting. If additional input is received in response to the 1915(b) Waiver renewal submission, prior to final approval, the department shall provide a response and inform the Center of Medicare & Medicaid Services (CMS) if the comments have an impact with regard to the content of the 1915(b) Waiver renewal.*

#### **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).*

*Through House Bill 1362, the 2013 ND Legislative Assembly directed DHS to expand medical assistance as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], to individuals under sixty five years of age with income below one hundred thirty eight percent of the federal poverty level, based on modified adjusted gross income. This included implementing the expansion by bidding through private carriers or utilizing the health insurance exchange.*

In order for the State to provide Medicaid Expansion through private carriers, an initial 1915(b) Waiver allowing managed care enrollment of the new adult group for Medicaid expansion was submitted to CMS with authority granted on December 20, 2013. North Dakota agreed to comply with the special terms and conditions (STCs) attached to the waiver to ensure compliance with statutory and regulatory compliance. The initial 1915(b) waiver authority ended on December 31, 2015.

On October 2, 2015, the State submitted a 1915(b) Waiver renewal request to CMS with authority granted on December 18, 2015. North Dakota agreed to comply with the special terms and conditions (STCs) attached to the waiver to ensure compliance with statutory and regulatory compliance. The current 1915(b) waiver authority ends December 31, 2017.

On October 2, 2017, the State submitted a 1915(b) Waiver renewal request to CMS with authority granted on December 14, 2017. North Dakota agreed to comply with the special terms and conditions (STCs) attached to the waiver to ensure compliance with statutory and regulatory compliance. The current 1915(b) waiver authority ends December 31, 2019.

#### Implementation and Milestones:

In August 2013, the State initiated a Request for Proposal (RFP) to solicit proposals for the Medicaid expansion population (e.g. new adult group). As a result of response to the RFP, the State anticipated awarding contracts to the following managed care organizations (MCO(s)) to cover the program statewide: Sanford Health Plan and Blue Cross Blue Shield of North Dakota.

In December 2013, one of the two responsive bidders to operate the State's managed care program withdrew its bid to participate resulting in ND awarding one contract to the following MCO: Sanford Health Plan.

The MCO contract start date was December 31, 2013 with the coverage for the expansion population beginning January 1, 2014. The State chose the section 1937 benchmark option of the commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state. In addition, the Alternative Benefit Plan (ABP) incorporates the Essential Health Benefits and ensures compliance with Mental Health and Substance Abuse parity. The group enrolled in the MCO is solely limited to those individuals eligible in the new adult group under the Medicaid expansion.

Federal Medicaid regulations require enrollees to have a choice of plans in the Metropolitan Statistical Areas (MSA's), and the MSA's in North Dakota are Burleigh County, Cass County, and Grand Forks. As the State was only able to award one statewide contract, ND was not able to provide a health plan choice to Medicaid Expansion recipients in urban areas of the State. The State submitted an 1115 waiver to ensure compliance as related to having one health plan choice for those Medicaid Expansion recipients in urban areas of the State with CMS granting authority on February 26, 2014. On August 26, 2015, the State submitted a request to CMS for an 1115 waiver extension as the authority initially granted was to end December 20, 2015. The State received a letter from CMS on December 18, 2015, indicating the 1115 waiver extension

request was approved. The 1115 waiver was allowed to expire as the provisions of the Medicaid Care Final Rules adopted May 6, 2016 resulted in ND no longer having designated urban areas and considered rural statewide, thus being exempt for having to provide a choice of managed care plans and in compliance with section 1932(a) of the Act and 42 CFR 438.52.

The State used the model streamline enrollment application developed by the United States Department of Health and Human Services for the purposes of eligibility determination. In addition to a ND DHS on-line application option, the State supported the collection of eligibility information over the telephone or via paper, in cases where potential enrollees did not have access to file electronically.

As an assessment state, the exchange of all required information for an eligibility determination to be made between the Federally Facilitated Marketplace (FFM) and the eligibility /enrollment system operated by the State was not initially supported. Those enrollees utilizing the FFM were sent to ND via a flat file and due to the complexities associated with this process; CMS authorized a waiver period in which the State was allowed to provide coverage to these individuals for up to 3 months or such time a full determination could be made. This waiver period was from January 1 through June 30, 2014. In July 2014, the State switched from an assessment state to a determination state for those who apply through the FFM. During this time the State continued to obtain a flat file until February 2015 in which the ability to complete account transfers between the FFM and State systems was established. The State did change back to be an assessment state on November 1, 2015, with the information of those applying through the FFM and identified as potentially eligible for ND State Medicaid sent to the State through account transfers between the FFM and State systems.

Through Senate Bill 2012, the 2019 ND Legislative Assembly directed DHS to continue ND Medicaid Expansion as implemented through a private carrier except for pharmacy services as of January 1, 2020. Thus, for this 1915(b) Waiver renewal the MCO will administer and manage medical benefits to those individuals eligible for ND Medicaid Expansion; however, the pharmacy benefits for the ND Medicaid Expansion population will be administered and managed by the Department through a fee-for-service Medicaid administration.

## A. Statutory Authority

### 1. Waiver Authority.

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

- a.  **1915(b) (1)** – ~~The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements.~~ This includes mandatory capitated programs.
- b.  **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCO(s)/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  
*Services pertaining to medical benefits as outlined within the State's ABP.*
- 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)
- FFS program (please describe)  
*Services pertaining to pharmacy benefits as outline within the State Plan shall be administered and managed by the Department through the fee-for-service Medicaid administration. For the FFS Program, no contract or other entity is*

required in relation to the administration or management of the pharmacy benefits as the Department will do this through existing, or new, pharmacy provider enrollment agreements with FFS payment made directly to individual pharmacy providers, as applicable.

## **2. Sections Waived.**

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

- a.  **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b.  **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
- c.  **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d.  **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e.  **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

## B. Delivery Systems

### 1. Delivery Systems.

The State will be using the following systems to deliver services:

- a.  **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCO(s) generally apply to these risk-comprehensive entities.  
Services pertaining to medical benefits as outlined within the State's ABP.
- b.  **PIHP:** Prepaid Inpatient Health Plan means an entity that:  
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCO(s) 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  
 different than stipulated in the state plan (please describe)

- f.  **Other:** (Please provide a brief narrative description of the model.)  
Services pertaining to pharmacy benefits as outlines within the State Plan shall be administered and managed by the Department through the fee-for-service Medicaid administration.

**2. Procurement.**

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

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

## C. Choice of MCO(s), PIHPs, PAHPs, and PCCMs

### 1. Assurances.

- The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
- The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

*As the State was not able to award two or more statewide MCO contracts, the State has elected to limit rural area residents to a single MCO in accordance to 42 CFR 438.52(b). The Medicare Advantage Health Service Delivery (HSD) Reference file indicates that the counties within ND meet the definition of being a rural area, thus for a managed care program authorized by a waiver under section 1915(b) of the Act the exception for rural area residents is applicable. The State will ensure the lack of choice of a MCO is not detrimental to beneficiaries' ability to access services by requiring the MCO to comply with the requirements within 42 CFR 438.52(b)(2) and to monitor network adequacy.*

### 2. Details.

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

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

*As the State was not able to award two or more statewide contracts, the State has elected to limit rural area residents to a single MCO in accordance to 42 CFR 438.52(b). The Medicare Advantage Health Service Delivery (HSD) Reference file indicates that the counties within ND meet the definition of being a rural area, thus for a managed care program authorized by a waiver under section 1915(b) of the Act the exception for rural area residents is applicable.*

### 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):

All counties within ND meet the definition of a "rural area" per the Medicare Advantage Health Service Delivery (HSD) Reference file designation in accordance to 42 CFR 438.52(b)(3).

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

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

As the State was not able to award two or more statewide contracts, the State has elected to limit rural area residents to a single MCO in accordance to 42 CFR 438.52(b). The Medicare Advantage Health Service Delivery (HSD) Reference file indicates that the counties within ND meet the definition of being a rural area, thus for a managed care program authorized by a waiver under section 1915(b) of the Act the exception for rural area residents is applicable. Thus, for the statewide service area beneficiaries will be limited to a single MCO. Beneficiaries enrolled with MCO shall be given a choice of care providers in their service area.

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

## D. Geographic Areas Served by the Waiver

### 1. General.

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

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

### 2. Details.

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

| <b>City/County/Region</b>     | <b>Type of Program</b><br>(PCCM, MCO, PIHP, or PAHP) | <b>Name of Entity</b><br>(for MCO, PIHP, PAHP) |
|-------------------------------|--|--|
| All counties in North Dakota. | MCO(s)   | Sanford Health Plan                            |
| All counties in North Dakota. | FFS  | DHS  |
|                               |  |  |

## E. Populations Included in Waiver

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

### 1. Included Populations.

The following populations are included in the Waiver Program:

- Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
  - Mandatory enrollment
  - Voluntary enrollment
  
- Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
  - Mandatory enrollment
  - Voluntary enrollment
  
- Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
  - Mandatory enrollment
  - Voluntary enrollment
  
- Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
  - Mandatory enrollment
  - Voluntary enrollment
  
- Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
  - Mandatory enrollment
  - Voluntary enrollment

- Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- Mandatory enrollment  
 Voluntary enrollment
- Medicaid Expansion (Group VIII)** are Medicaid beneficiaries who are eligible for Medicaid as result of the new adult group in the Medicaid expansion authorized under the Affordable Care Act.
- Mandatory enrollment  
 Voluntary enrollment
- TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.
- Mandatory enrollment  
 Voluntary enrollment

## **2. Excluded Populations.**

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

- Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- Poverty Level Pregnant Women --**Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- Other Insurance--**Medicaid beneficiaries who have other health insurance.
- Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

- Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- Other** (Please define):

*Individuals who are eligible for Medicaid as the result of the new adult group in the Medicaid expansion authorized under the Affordable Care Act may be considered excluded from the waiver program if the qualifications of the exempt populations as outlined in Section 1937(a)(2) of the Act are met. As identified these individuals may choose to receive the Medicaid State Plan rather than the ABP.*

*As indicated in the approved State's ABP, individuals who are eligible for Medicaid as the result of the new adult group in the Medicaid expansion authorized under the Affordable Care Act are excluded from the waiver program with Medicaid State Plan fee-for-service benefits provided if those individuals are incarcerated who receive only qualifying inpatient care, those non-citizen individuals who receive treatment for an emergency medical condition as required under 42 CFR 435.139, and/or those with Hospital Presumptive Eligibility until a full determination can be made.*

## F. Services

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

### 1. Assurances.

- The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2) *and ABP, as applicable.*
  - 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).
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.
- The State assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

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

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

## **2. Emergency Services.**

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

- The 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:

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

## **4. FQHC Services.**

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

- The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives

him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

The MCO(s) must ensure that the Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), in the MCO's service area, are enrolled as network providers regardless of having a contract with the MCO. The Provider Network Directory must specify that the Federally Qualified Health Centers and Rural Health Clinics are within the network and must provide telephone and address information for each location. This requirement will also be incorporated into MCO contracts.

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

#### 5. EPSDT Requirements.

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

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

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

#### 7. Self-referrals.

- The State requires MCO(s)/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 MCO must allow enrollees who are temporarily residing outside of the statewide service area, yet remain eligible for the 1915(b) Waiver population, to self-refer with regard to obtaining services from providers not within the MCO's network if one of the following applies:
- Emergent or urgent services;
  - Family planning services; or

- Authorized self-referral due to services not being available or feasible within MCO's network

## Part II: Access

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

### A. Timely Access Standards

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

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

#### 2. Details for PCCM program.

Not Applicable

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. \_\_\_Hospitals (please describe):
6. \_\_\_Mental Health (please describe):
7. \_\_\_Substance Abuse Treatment Providers (please describe):
8. \_\_\_Urgent care (please describe):
9. \_\_\_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. \_\_\_\_\_ Hospitals (please describe):
6. \_\_\_\_\_ Mental Health (please describe):
7. \_\_\_\_\_ Substance Abuse Treatment Providers (please describe):
8. \_\_\_\_\_ Urgent care (please describe):
9. \_\_\_\_\_ Other providers (please describe):

d. \_\_\_\_\_ **Other Access Standards** (please describe)

**3. Details for 1915(b)(4) FFS selective contracting programs:**

*Not Applicable*

Please describe how the State assures timely access to the services covered under the selective contracting program.

## B. Capacity Standards

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

- The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

### 2. Details for PCCM program.

*Not Applicable*

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.

| <b>Providers</b>                           | <b># Before Waiver</b> | <b># In Current Waiver</b> | <b># Expected in Renewal</b> |
|--|------------------------|----------------------------|------------------------------|
| Pediatricians                              |                        |                            |                              |
| Family Practitioners                       |                        |                            |                              |
| Internists                                 |                        |                            |                              |
| General Practitioners                      |                        |                            |                              |
| OB/GYN and GYN                             |                        |                            |                              |
| FQHCs                                      |                        |                            |                              |
| RHCs                                       |                        |                            |                              |
| Nurse Practitioners                        |                        |                            |                              |
| Nurse Midwives                             |                        |                            |                              |
| 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.

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

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

**3. Details for 1915(b)(4) FFS selective contracting programs:**

*Not Applicable*

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

## C. Coordination and Continuity of Care Standards

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

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.
  
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
  
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

The following items are required.

- a.  The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
  
- b.  **Identification.** The State has a mechanism to identify persons with special health care needs to MCO(s), PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

*The State has defined persons with special health care needs as those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions who also require health and related services of a type or amount beyond that required by an enrollee generally. It is the responsibility of the MCO(s) to identify these individuals and ensure there is access to all services to meet the health needs of enrollees with special healthcare needs in accordance with the covered and non-covered services and limitations. This requirement will also be incorporated into MCO contracts.*

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

The State requires the MCO(s) to maintain mechanisms to assess each enrollee for special health care needs both upon initial enrollment as well as on an ongoing basis to identify existing enrollees with special health care needs. For initial screening, the MCO(s) may use assessment tools to identify enrollees with special needs. The assessment tool must cover areas regarding disabilities and other specific medical conditions (including, but not limited to heart disease, diabetes, asthma, hypertension, chronic pain, etc.) The ongoing monitoring by the MCO(s) must include an analysis of claims for certain diagnostic procedure codes, a review of inpatient care and referrals. Once identified, these cases are referred to care coordinators who perform more detailed needs assessments and care coordination. The health plan/MCO will be responsible for the program care coordinators. The care coordinator may be a nurse, social worker, or other assigned individual that is responsible for the identified enrollee. The care coordinator will assist with care coordination and other identified needs of the enrollee.

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

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

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

### **3. Details for PCCM program.**

*Not Applicable*

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:**

*Not Applicable*

If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

### Part III: Quality

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

- 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.
  
- 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.
  
- Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCO(s) and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCO(s) and PIHPs. 2019 ND Medicaid Expansion Quality Strategy
  
- 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     | Qlarant Quality Solutions Inc | X                    | X                    | X                   |

EQR Study Activities include the EQRO completing an Independent Assessment the MCO's program impact, access, and quality.

EOR Mandatory Activities include the following:

- Validation of performance improvement projects (PIP) required in accordance with 42 CFR §438.330(b)(1) that were underway during the preceding 12 months;
- Validation of performance measures required in accordance with 42 CFR §438.330(b)(2) or MCO performance measures calculated by the State during the preceding 12 month;
- A review, conducted within the previous 3-year period, to determine the MCO's compliance with the standards set forth in 42 CFR §438 Subpart D and the Quality assessment and performance improvement requirements described in 42 CFR §438.330; and
- Validation of MCO network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR §438.68 and, as STATE's 1915(b) Waiver mandatorily enrolls Indians, in 42 CFR §438.14(b)(1).

EOR Optional Activities include the following:

- Validation of encounter data reported by a MCO;
- Validation of consumer or provider surveys of Quality of care;
- Calculation and validation of performance measures in addition to those reported by an MCO;
- Conduction and validation of performance improvement projects in addition to those conducted by an MCO; and
- Conduction of studies on Quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

- The State assures CMS that it complies or will comply with 42 CFR 438 Subpart E by the applicability dates as specified 42 CFR 438.310(d)(1) & (2) and 42 CFR 438.334(a)(3).

**2. Assurances For PAHP program.**

Not Applicable

\_\_\_\_\_ 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.**

*Not Applicable*

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:**

*Not Applicable*

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:

## Part IV: Program Operations

### A. Marketing

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

#### 1. Assurances

- The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

#### 2. Details

##### a. **Scope of Marketing**

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

*The State will allow indirect marketing such as brochures, trainings, presentations, and/or radio and television advertisements upon prior approval from the State. All marketing materials must be reviewed and approved by the State prior to their use, publication or distribution. The MCO(s) marketing and educational activities must comply with 42 CFR 438.104. The MCO(s) must*

submit a proposed marketing plan that defines their approach for marketing and this plan must be prior approved by the State. These requirements will be incorporated into MCO contracts

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

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

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

The State prohibits all gifts or incentives to potential enrollees. The State and the EORO will monitor the prohibition by including a question on the annual survey asking the enrollee to identify if they have received any gift or incentive to join the plan. If it is confirmed that gifts or incentives have been given, the Department will determine an appropriate sanction.

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

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

The State requires any language that meets the criteria below to be translated.

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

- i.  The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii.  The languages comprise all languages in the service area spoken by approximately \_\_\_ percent or more of the population.
- iii.  Other (please explain):

The MCO(s) are required to ensure that translation services are provided for written marketing and member education materials for the top 15 non-English languages spoken by individuals with Limited English Proficiency in ND, in accordance with guidance issued under Section 1557, CMS, HHS, and HHS OCR. The State requires that

*MCO(s) and any contractors have translation services for those who speak any language.*

## **B. Information to Potential Enrollees and Enrollees**

### **1. Assurances.**

- The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

### **2. Details.**

#### **a. Non-English Languages**

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

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

- The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
- The languages spoken by approximately \_\_\_ percent or more of the potential enrollee/ enrollee population.
- Other (please explain):

The MCO(s) must meet all requirements in accordance with 42 CFR 438.10 and ensure the capacity to meet the needs of prevalent non-English linguistic groups in their service areas and make available materials in alternative formats, upon request as outlined within the contract.

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

The MCO(s) must provide interpretive services for languages on an as-needed basis at no cost to an enrollee. These requirements must extend to both in-person and telephone communications to ensure that an enrollee is able to communicate with the MCO(s) and providers.

The MCO(s) shall promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural or ethnic backgrounds.

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

Enrollees will receive an educational letter developed by the State along with the affirmative enrollment letter that details: health plan options, services covered, contact information of the plan(s), etc. Once individuals are enrolled with the plan and defined as enrollees they will receive information from the MCO(s) such as a member handbook.

#### b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- 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.  the State  
ii.  State contractor (please specify): \_\_\_\_\_  
iii.  the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

## C. Enrollment and Disenrollment

### 1. Assurances.

- The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

### 2. Details.

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

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

*The State will notify enrollees of the available MCO upon the enrollee being determined eligible. Enrollees will receive an educational letter developed by the State along with the affirmative enrollment letter that details: health plan information, services covered, contact information of the plan, etc.*

*As applicable, the State will have general information about the MCO at the county social service offices, consumer advocacy organizations and other community based organizations.*

**b. Administration of Enrollment Process.**

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

*The MCO will utilize eligibility and enrollment data provided by the State in which eligible individuals have been auto-assigned and the plan is responsible for enrolling the individual in their health plan, providing all relevant enrollment information such as instructional materials, handbooks, etc.*

**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.):
- If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.
  - i. \_\_\_ Potential enrollees will have 7 days/month(s) to choose a plan.
  - ii. \_\_\_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an

MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- 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) for services pertaining to medical benefits and into the fee-for-service Medicaid for services pertaining to pharmacy benefits.
  - on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
  - on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: \_\_\_\_\_
- The State provides **guaranteed eligibility** of \_\_\_\_ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
- The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

- The State allows enrollees to **disenroll** from/transfer between MCO(s)/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
  - i.  Enrollee submits request to State.
  - ii.  Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
  - iii.  Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

Except for those individuals identified as meeting the requirements of one of the exempt populations within Section A Part I.E.2 as these exempt populations are not automatically enrolled.

- 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):
- The State **does not have a lock-in**, and enrollees in MCO(s)/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.
- The State permits **MCO(s)/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:
- i.  MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
  - ii.  The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
  - iii.  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.  The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

## D. Enrollee rights.

### 1. Assurances.

- The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
  
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
  
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
  
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
  
- The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

## **E. Grievance System**

### **1. Assurances for All Programs.**

States, MCO(s), PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

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

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

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

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

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

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

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

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

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

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

b. **Timeframes**

- The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).
- The State's *preferred* timeframe within which an enrollee should ~~must~~ file a **grievance** is 90 days. However, per 42 CFR 438.402(c)(2) an enrollee may file a grievance with the MCO at any time.

c. **Special Needs**

- The State has special processes in place for persons with special needs. Please describe.  
The MCO(s) must give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

**4. Optional grievance systems for PCCM and PAHP programs.**

*Not Applicable*

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

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

\_\_\_\_\_ The grievance procedure is operated by:

\_\_\_\_\_ the State

\_\_\_\_\_ the State's contractor. Please identify: \_\_\_\_\_

\_\_\_\_\_ the PCCM

\_\_\_\_\_ the PAHP.

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

\_\_\_\_\_ Has a committee or staff who review and resolve requests for review. Please

describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

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

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

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

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

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

Other (please explain): \_\_\_\_\_

## F. Program Integrity

### 1. Assurances.

- The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:
- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
  - (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.
- The prohibited relationships are:
- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
  - (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
  - (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
- The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
- (1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
  - (2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
  - (3) Employs or contracts directly or indirectly with an individual or entity that is
    - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

### 2. Assurances For MCO or PIHP programs

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

- State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP.  
If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- 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 MCO(s) 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.

## **Part I: Summary Chart of Monitoring Activities**

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

Please note:

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

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

| Monitoring Activity  | Evaluation of Program Impact |           |                        |                      |                                 |           | Evaluation of Access |                            |                             | Evaluation of Quality      |                       |                    |
|--|------------------------------|-----------|------------------------|----------------------|---------------------------------|-----------|----------------------|----------------------------|-----------------------------|----------------------------|-----------------------|--------------------|
|  | Choice*                      | Marketing | Enroll -<br>Disenroll* | Program<br>Integrity | Information to<br>Beneficiaries | Grievance | Timely Access        | PCP/Specialist<br>Capacity | Coordination/<br>Continuity | Coverage/<br>Authorization | Provider<br>Selection | Quality of<br>Care |
| <i>*Evaluation of Program Impact – Choice:<br/>as the State only has one MCO the aspect of choice<br/>does not apply</i> |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Accreditation for Non-duplication  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Accreditation for Participation  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Consumer Self-Report data  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       | X                  |
| Data Analysis (non-claims)   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Enrollee Hotlines  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Focused Studies  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Geographic mapping   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Independent Assessment   |                              | X         |                        | X                    | X                               | X         | X                    | X                          | X                           | X                          | X                     | X                  |
| Measure any Disparities by Racial or Ethnic Groups   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Network Adequacy Assurance by Plan   |                              |           |                        |                      |                                 |           |                      | X                          |                             |                            |                       |                    |
| Ombudsman  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| On-Site Review   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Performance Improvement Projects   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       | X                  |
| Performance Measures   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       | X                  |
| Periodic Comparison of # of Providers  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Profile Utilization by Provider Caseload   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Provider Self-Report Data  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Test 24/7 PCP Availability   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Utilization Review   |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |
| Other: (describe)  |                              |           |                        |                      |                                 |           |                      |                            |                             |                            |                       |                    |

## Part II: Details of Monitoring Activities

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

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

- Applicable programs (if this waiver authorizes more than one type of managed care program)
  - Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
  - Detailed description of activity
  - Frequency of use
  - How it yields information about the area(s) being monitored
- a.  Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)
- NCQA – Applicable if MCO has NCQA accreditation for the population as indicated within the waiver and may be taken into consideration to during waiver prevent duplicated efforts.
- JCAHO
- AAAHC
- Other (please describe)
- b.  Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
- NCQA
- JCAHO
- AAAHC
- Other (please describe)
- c.  Consumer Self-Report data
- CAHPS (please identify which one(s)) **Adult 4.0 or most current version**
- State-developed survey
- Disenrollment survey
- Consumer/beneficiary focus groups

The MCO(s) will annually mail, tabulate and report to the State the results of the CAHPS survey to enrollees. The Department may include supplemental questions to the survey. This survey will allow enrollees to evaluate their experiences with health care.

- d.  Data Analysis (non-claims)
- Denials of referral requests
  - Disenrollment requests by enrollee
    - From plan
    - From PCP within plan
  - Grievances and appeals data
  - PCP termination rates and reasons
  - Other (please describe)
- e.  Enrollee Hotlines operated by State
- f.  Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
- g.  Geographic mapping of provider network
- h.  Independent Assessment of program impact, access, *and* quality (**Required** for first two waiver periods).

*The State contracts with an EQRO to evaluate program impact, access, and quality of the MCO(s). In particular, the following shall be taken into consideration: Marketing, Program Integrity, Information to Beneficiaries, Grievances, Timely Access, PCP/Specialist Capacity, Coordination/Continuity, Coverage/Authorization, Provider Selection, and Quality of Care. Quality of Care does extend to evaluation of selected performance measures and performance improvement projects. As this is the fourth waiver period, the State will not be completing an independent assessment to evaluate program cost effectiveness. The Annual Technical Report as submitted by the EQRO, pursuant to 42 CFR 438.364(c), may serve as the required Independent Assessment document if all above-mentioned aspects as indicated are included with the document.*

- i.  Measurement of any disparities by racial or ethnic groups.
- j.  Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

*The State will require the MCO(s) to annually submit to the State assurances that they have adequate networks with regard to PCP/Specialist Capacity. The MCO(s) must have plans in place to pay for and coordinate care or services if the plan is unable to provide necessary covered services in a timely manner. This activity will yield confirmation of an appropriate provider network or a need for improved network access.*

- k.  Ombudsman
- l.  On-site review
- m.  Performance Improvement projects [**Required** for MCO/PIHP]
  - Clinical
  - Non-clinical

*The State contracts with an EORO to annually assess clinical and non-clinical areas of service or delivery of the health plan. This shall include the evaluation of program impact, access, and quality, identifying potential issues or concerns which may lead to the development and implementation of Performance Improvement Projects as needed.*

- n.  Performance measures [**Required** for MCO/PIHP]
  - Process
  - Health status/outcomes
  - Access/availability of care
  - Use of services/utilization
  - Health plan stability/financial/cost of care
  - Health plan/provider characteristics
  - Beneficiary characteristics

*The State contracts with an EORO to evaluate program impact, access, and quality of the MCO(s). Performance Measures pertaining to the above-mentioned areas shall be assessed allowing the identification of potential issues or concerns which may lead to the development and implementation of Performance Improvement Projects as needed to ensure quality of care for beneficiaries.*

- o.  Periodic comparison of number and types of Medicaid providers before and after waiver
- p.  Profile utilization by provider caseload (looking for outliers)
- q.  Provider Self-report data
  - Survey of providers
  - Focus groups
- r.  Test 24 hours/7 days a week PCP availability
- s.  Utilization review (e.g. ER, non-authorized specialist requests)
- 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 MCO(s)/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

- This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.
- This is a renewal request.
- This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
  - The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy: Confirmation it was conducted as described:

\_\_\_ Yes

\_\_\_ No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

| <b>Evaluation of Program Impact</b>  |   |
|--|---|
| <b><u>CHOICE</u></b>   |   |
| <b>STRATEGY</b>  | <b>Not Applicable</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain | <i>The State's 2018-2019 1915(b) Waiver was approved, authorizing the State to limit rural area residents to a single MCO in accordance to 42 CFR 438.52(b). Per the Medicare Advantage Health Service Delivery (HSD) Reference file, all the counties within ND meet the definition of being a rural area; thus, the State had one health plan choice for Medicaid Expansion recipients throughout the State. Subsequently, as the State only had one MCO the aspect of choice does not apply. Within the approved 2018-2019 1915(b) Waiver, this monitoring activity was noted as not being applicable.</i> |
| Summary of Results:  |   |
| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b><u>MARKETING</u></b>  |   |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <i>The on-site Independent Assessment performed by the EQRO confirmed that the MCO has met the requirements and is in compliance with marketing as outlined within the contract and as indicated within 42 CFR Part 438. Throughout the waiver period there have been no reports or discoveries of any unauthorized marketing materials or mass communication to beneficiaries.</i>   |
| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b><u>ENROLL - DISENROLL</u></b>   |   |

| STRATEGY   | Not Applicable  |
|--|---|
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain | <p><i>The State's 2018-2019 1915(b) Waiver was approved, authorizing the State to limit rural area residents to a single MCO in accordance to 42 CFR 438.52(b). Per the Medicare Advantage Health Service Delivery (HSD) Reference file, all the counties within ND meet the definition of being a rural area; thus, the State had one health plan choice for Medicaid Expansion recipients throughout the State. Subsequently, as the State only had one MCO the aspect of enrollment and disenrollment between MCOs does not apply. Within the approved 2018-2019 1915(b) waiver, this monitoring activity was noted as not being applicable.</i></p>   |
| Summary of Results:  |   |
| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b><u>PROGRAM INTEGRITY</u></b>  |   |
| STRATEGY   | Independent Assessment  |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <p><i>The on-site Independent Assessment performed by the EQRO confirmed that the MCO has met the requirements and is in compliance with program integrity as outlined within the contract and as indicted within 42 CFR Part 438. The MCO has policy and procedure that address program integrity requirements with established processes for investigating provider and beneficiary FWA including the mandate to report suspected cases to the State. The MCO has a formal Fraud, Waste, and Abuse (FWA) Program along with a designated Compliance Officer. The MCO utilizes a number of system edits and programmatic reviews of data designed to detect potential FWA. The MCO does contract with two vendors to conduct pharmacy and medical FWA activities which include the review and analysis to identify suspect or potential incorrect, fraudulent, or abusive billing practices. The MCO maintains an FWA Tracking Report which includes suspected cases and captures the State notification process. The MCO's credentialing and recredentialing process ensures that the organization does not employ or contract with providers excluded from participation in federal health programs.</i></p> |
| Problems Identified  |   |
| Corrective Action:   |   |

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| (plan/provider level)  |  |
| Program Change:<br>(system-wide level)   |  |
| <b>INFORMATION TO BENEFICIARIES</b>  |  |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>  |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |  |
| Summary of Results:  | <i><u>The on-site Independent Assessment performed by the EQRO confirmed that MCO has met the requirements and is in compliance relating to the information to beneficiaries as outlined within the contract and as indicated within 42 CFR 438. It was noted that the information to beneficiaries was appropriate with it being presented in formats which are easily understood. MCO provides access to auxiliary aids and services when requested. The option of oral interpretation and translation services are available to enrollees. Based on MCO’s 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Survey (assessing MY 2018 member experience), 55.81% of members responding to the survey indicated that written materials or the internet provided the information they needed; 96.23% of members indicated that health plan forms were easy to fill out.</u></i> |
| Problems Identified  |  |
| Corrective Action:<br>(plan/provider level)  |  |
| Program Change:<br>(system-wide level)   |  |
| <b>GRIEVANCES</b>  |  |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>  |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |  |
| Summary of Results:  | <i><u>The on-site Independent Assessment performed by the EQRO confirmed that the MCO does maintain a grievance system that allows enrollees to file grievance, appeals, and request state fair hearings with timely access to</u></i>   |

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|  | <i>resolutions. The MCO has met the requirements and is in compliance relating to grievances as outlined within the contract. The EORO noted concerns with language as indicated within policy and enrollee/provider information which need to be revised to ensure process compliance in relation to 42 CFR 438.</i>   |
| Problems Identified  | <p><i>Through a random sample review of grievances/appeals, along with policy review, the EORO identified the following areas as concerns with compliance in relation to 42 CFR 438 requiring clarification.</i></p> <p><i>The MCO grievance/appeal policy language does not explicitly indicate the following:</i></p> <ul style="list-style-type: none"> <li>• <i>need to obtain a written and signed appeal request following an oral appeal request;</i></li> <li>• <i>individuals making decisions have the appropriate clinical expertise in treating the enrollee’s condition/disease; and</i></li> <li>• <i>individuals making decisions take into account all comments, documents, records, and other information submitted by enrollee or their representative without regard to whether such information was submitted or considered with initial adverse benefit determination.</i></li> </ul> <p><i>MCO has had a total of 4 grievances in which the resolution for one extended the timeframe by several months. In addition, inconsistent information pertaining to oral appeal requests, grievance resolution within 90 day timeframe, 14 day calendar day extension, and state fair hearing for staff, members, and providers.</i></p> |
| Corrective Action:<br>(plan/provider level)  | <i>Information provided to the MCO on the findings. MCO revising existing policy to include the explicit language as indicated above. MCO will be updating member and provider materials to include clear and consistent language regarding oral appeals, timeframes, acceptable extension rational, and state fair hearing information. Once finalized the revised policies and materials will be submitted to the State-Quality Committee for review and approval – with the anticipated time for submission/review by end of calendar year. Following approval MCO will provide information about internal process to update MCO staff ensuring consistent message is given to members and providers.</i>  |
| Program Change:<br>(system-wide level)   |   |
| <b>Evaluation of Access</b>  |   |
| <b><u>TIMELY ACCESS</u></b>  |   |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |

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| Summary of Results:  | <i>The on-site Independent Assessment performed by the EORO confirmed that the MCO provides timely access to health services to those enrolled. Based on the MCO's 2019 CAHPS Member Survey (assessing MY 2018 member experience), the MCO scored 78.94% on the Getting Care Quickly Composite. More specifically, 75.52% of members responding to the survey indicated that they received routine care as soon as it was needed and 82.35% indicated that they received urgent care as soon as it was needed. Further, 76.25% of responding members reported that they received an appointment with a specialist as soon as it was needed.</i> |
| Problems Identified  | <i>It was noted that for timely access to next appointment, the following provider types have composite scores below 90%. In particular, primary care (54.17%), maternity (47.37%), Behavioral Health – Non-Prescriber (37.50%), Behavioral Health – Prescriber (47.62%), Specialist – high impact (51.50%), and Specialist – high volume (71.40%). While the MCO did meet standards for timely access as evidenced by its survey, the majority of enrollees do not perceive this as an issue per the CAHPS survey in which 78.94% of respondents reported getting care quickly.</i>  |
| Corrective Action:<br>(plan/provider level)  | <i>Information provided to MCO on findings. Recommending that the MCO work with any network provider type with a score below 90% to identify what may be impacting timely access to next appointment, implement corrective actions for provider(s), and assist with improvement strategies implementation. In addition, evaluate survey process to ensure accurate is information being captured. The MCO shall continue to monitor network adequacy – as results are known, based on timing of CAHPS reporting, these will be provided to the State-MCO Quality Committee.</i>   |
| Program Change:<br>(system-wide level)   |   |
| <b><u>PCP/SPECIALIST CAPACITY</u></b>  |   |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <i>The on-site Independent Assessment performed by the EORO confirmed that the MCO provides network adequacy as related to PCP/Specialist. Per MCO's 2019 CAHPS Survey (assessing MY 2018 member experience), 84.66% of members reported ease in getting needed care, tests, or treatment. The MCO's Getting Needed Care Composite was scored as being 80.46%. The MCO does meet the requirements as related to Primary Care Providers to Member Ratio of 1:2,500 with the following PCP types and provider to member ratios:</i>   |

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|  | <ul style="list-style-type: none"> <li>➤ <u>Family Medicine - 1:12</u></li> <li>➤ <u>Internal Medicine - 1:54</u></li> <li>➤ <u>Obstetrics and Gynecology - 1:81</u></li> </ul> <p>In addition, the MCO identified the following requirements as related to High Volume Specialist to Member Ratio of 1:3000 and Behavioral/Mental Health/Substance Use Disorder Practitioner to Member Ratio of 1:3000 with the following results:</p> <ul style="list-style-type: none"> <li>➤ <u>Cardiology - 1:193</u></li> <li>➤ <u>Dermatology - 1:462</u></li> <li>➤ <u>Gastroenterology - 1:296</u></li> <li>➤ <u>Nephrology - 1:411</u></li> <li>➤ <u>Otolaryngology - 1:274</u></li> <li>➤ <u>Surgery - 1:102</u></li> <li>➤ <u>Urology - 1:315</u></li> <li>➤ <u>Psychiatry (Psychiatry and Neurology) - 1:16</u></li> <li>➤ <u>Psychologist: Psychology/Behavior Health - 1:83</u></li> </ul> |
| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b>STRATEGY</b>  | <b>Network Adequacy Assurance by Plan</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <p><u>As indicted above the on-site Independent Assessment performed by the EQRO confirmed that the MCO provides network adequacy as related to PCP/Specialist. In addition, MCO does provide network adequacy as related to PCP/Specialist through assurances to the State that the MCO contracts with 99% of available providers in North Dakota which is supported by provider directories and geo-access reports which are reviewed and evaluated. As the State requires that PCP services be available to beneficiaries within 50 miles in relation to one’s residence the following results were noted:</u></p> <ul style="list-style-type: none"> <li>➤ <u>Hospitals 99.9%</u></li> </ul>  |

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|  | <ul style="list-style-type: none"> <li>➤ <u>Internal Medicine 98.6%</u></li> <li>➤ <u>OB/GYN 87.7%</u></li> <li>➤ <u>Pediatrics 86.6%</u></li> <li>➤ <u>Pharmacies 99.9%</u></li> </ul> <p><u>Given the rural nature of the State including some “frontier” areas, the State’s compliance threshold for primary care is 85% which was met by the MCO. Acknowledging the potential challenges with timely access especially for those living in rural areas, the State and MCO actively monitor for and reach out to new provider – offering assistance with becoming a network provider. The MCO has and continues to work with providers to establish options for tele-health or remote provider clinic days in rural areas. It should be noted that the MCO does have processes in place to assist and provide coverage for transportation to medical appointments for routine, non-emergent care. Thus, ensuring access despite some services being more than 50 miles from one’s residence. In addition, processes are in place allowing beneficiaries to access out-of-network providers if services are relating to an emergent/urgent need, family planning, or network provider not being able to provide service.</u></p> |
| Problems Identified  |  |
| Corrective Action:<br>(plan/provider level)  |  |
| Program Change:<br>(system-wide level)   |  |
| <b><u>CORRDINATION/CONTINUITY</u></b>  |  |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>  |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |  |
| Summary of Results:  | <p><u>The on-site Independent Assessment performed by the EORO confirmed that the MCO provides access for coordination and continuity. The MCO maintains a complex case management program. During 2018 the MCO’s Case Managers collaborated with PCPs to coordinate services and care for enrollees identified as having special needs. The MCO has the following disease management programs in place for 2018 Congested Heart Failure, Hypertension, Diabetes, Coronary Artery Disease, and Asthma.</u></p> <p><u>Per MCO’s 2019 CAHPS Member Survey (assessing MY 2018 member experience), the Coordination of Care Composite was rated 83.58%; however, it should be noted the measure was considered “non-applicable” since the response rate for this measure was less than 100.</u></p>  |

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| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b>Evaluation of Quality</b>   |   |
| <b><u>COVERAGE/AUTHORIZATION</u></b>   |   |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <i><u>The on-site Independent Assessment performed by the EORO evaluated performance measure related to coverage and authorization. The MCO has a comprehensive health care services benefit package and utilizes consistent review criteria for authorization determinations. The quality of the criteria is based on nationally recognized guidelines which the MCOs Physician Quality Committee reviews at least annually. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a provider who has the appropriate clinical expertise in treating the member’s condition. If a determination is made to deny authorization of services, a letter of denial is sent to the member, provider of service, and the attending physician with the appeals process attached. During the on-site review, a sample of denial files was reviewed. All letters were appropriate and considered best practice. The letters included clear, comprehensive explanations for denial of services and provided alternative, researched solutions when possible. All letters included appeal rights and the appeal form was included as an attachment.</u></i> |
| Problems Identified  |   |
| Corrective Action:<br>(plan/provider level)  |   |
| Program Change:<br>(system-wide level)   |   |
| <b><u>PROVIDER SELECTION</u></b>   |   |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>   |
| Confirmation (it was conducted as described):  |   |

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| <input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain  |  |
| Summary of Results:  | <p><i>The on-site Independent Assessment performed by the EQRO evaluated the aspect of provider selection. The MCO has established criteria for Credentialing and Re-credentialing of Network Providers which ensure that the organization does not employ or contract with providers excluded from participation in federal health care programs. There are procedures in place to monitor Medicare and Medicaid sanctions and state sanctions or limitations on licensure, on an ongoing basis with sanction websites checked every 30 days. Through a random sample review no issues or concerns were identified. It revealed that the MCO does not discriminate or deny participation of any provider who is acting within his/her license or certification under applicable state law solely on the basis of that license or certification, nor does it discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.</i></p> |
| Problems Identified  |  |
| Corrective Action:<br>(plan/provider level)  |  |
| Program Change:<br>(system-wide level)   |  |
| <b>QUALITY OF CARE</b>   |  |
| <b>STRATEGY</b>  | <b>Independent Assessment</b>  |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |  |
| Summary of Results:  | <p><i>The on-site Independent Assessment performed by the EQRO determined that the MCO has an established Quality Program which relates to quality care including both the clinical and non-clinical aspects. The program consists of the Quality Improvement Committee and the Physician Quality Committee. The MCO has an active Quality Work Plan for its ND Medicaid Expansion line of business. The work plan identifies each activity and identifies the associated standard (or requirement), person(s) responsible, and reporting frequency. Some of the activities identified include: appeals, telephone statistics, fraud and abuse, provider utilization profiling, pregnancy/deliveries, and access and availability. The MCO had developed and completed a Quality Improvement Program Evaluation specific to Medicaid Expansion for MY2018 which includes an analysis of PIPs</i></p>   |

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|  | <i>and other key performance measures. In addition, MCO separately reports results of performance measures, member satisfaction, and performance improvement projects.</i>   |
| Problems Identified  |  |
| Corrective Action:<br>(plan/provider level)  |  |
| Program Change:<br>(system-wide level)   | <i>As the Medicaid Expansion Program continues to mature – EQRO made recommendation to include trending information with reports and consider establish real time or current reporting. This is something which the State-MCO Quality Committee will take under advisement.</i>  |
| <b>STRATEGY</b>  | <b>Consumer Self-Report Data</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |  |
| Summary of Results:  | <i>The MCO contracts with a certified CAHPS vendor who conducted the 2019 CAHPS 5.0 Member Satisfaction Survey (assessing MY 2018 member experience) which captures enrollee feedback about the MCO, providers, and member perception about care. The MCO performance results related to the CAHPS results can be found in Attachment E under Appendix IV. As compared to NCOA Quality Compass benchmarks, the MCO performed above average or exceeded on the majority of the CAHPS measures. The MCO performed below the national averages on the following measures:</i> <ul style="list-style-type: none"> <li>➤ <i>Rating of Health Plan (% with response of 8+9+10) was 74.38%</i></li> <li>➤ <i>Getting Care Quickly Composite was 78.94%</i></li> <li>➤ <i>Getting Needed Care Composite was 80.46%</i></li> <li>➤ <i>Health Promotion and Education Composite was 61.59%</i></li> <li>➤ <i>Flu Vaccination: Had Flu Shot or Spray in the Nose since July 1, 2018 was 38.93%</i></li> </ul> |
| Problems Identified  | <i>As noted above under Summary of results – the MCO performed below the national average on some of the CAHPS measures.</i>   |
| Corrective Action:<br>(plan/provider level)  | <i>MCO shall continue with strategies to improve measure rates which are aimed at providing education to both providers and beneficiaries. In addition, a potential concern may pertain to the change with MCO Service Area</i>  |

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|   | <p><i>and the establishment of Network Providers with criteria needing to be met for coverage when obtaining services from an Out-of-Network Provider as of January 1, 2018. With educational efforts including both member and provider materials throughout 2018 into 2019, State- Quality Committee anticipates improvements with regard to these measure with next CAHPS Survey. MCO will provide updates to the State-MCO Quality Committee and if the performance in these measures continues to be a concern with the next CAHPS Survey consideration will be given to incorporate these into potential PIPS based on appropriateness for population. The State-Quality Committee does take into consideration that the CAHPS Survey is subjective and perception/understanding of questions by respondents can vary.</i></p>   |
| <p>Program Change:<br/>(system-wide level)</p>  |  |
| <p><b>STRATEGY</b></p>  | <p><b>Performance Improvement Projects</b></p>   |
| <p>Confirmation (it was conducted as described):<br/> <input checked="" type="checkbox"/> YES<br/> <input type="checkbox"/> NO – Please Explain</p> |  |
| <p>Summary of Results:</p>  | <p><i><u>The on-site Independent Assessment performed by the EQRO evaluated the MCO’s Performance Improvement Projects (PIP) relating to quality of care. Current performance results related to the PIPs can be found in Attachment E.</u></i></p> <p><b><u>The Comprehensive Diabetes Care PIP focuses on the management of members with diabetes (type I &amp; type 2).</u></b></p> <p><i><u>For remeasurement 1 (MY 2018), out of the seven Comprehensive Diabetes Care performance measures, four improved compared to baseline performance. These performance measures were: HbA1c Control &lt; 8% (55.96%), which increased by 0.95 percentage points from baseline (55.01%); HbA1c Control &lt; 7% for a Selected Population (41.61%), which increased by 1.95 percentage points from baseline (39.66%); Eye Exam (Retinal) Performed (51.12%), which increased by 1.03 percentage points from baseline (50.09%); and Medical Attention for Nephropathy (93.61%), which increased by 2.40 percentage points from baseline (91.21%). The performance measures that decreased from baseline rates were HbA1c Testing (92.57%), which decreased by 0.05 percentage points from baseline (92.62%); and Blood Pressure Control &lt;140/90 (76.86%), which decreased by 1 percentage point from baseline (77.86%). There was an increase in the rate for HbA1c Poor Control &gt;9%. For this particular measure, a lower rate is better. The rate increased by 1.54 percentage points (from 30.58% to 32.12%).</u></i></p> |

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|   | <p><u>Two out of the seven performance measures exceeded the MCO goals: HbA1c Control &lt; 7% for a selected population exceeded the MCO goal of 41% by 0.61 percentage points and Medical Attention for Nephropathy exceeded the MCO goal of 92% by 1.61 percentage points, and additionally, has increased this MCO goal for MY 2019 by 2 percentage points.</u></p> <p><u>Although there were four performance measures that improved and two performance measures that exceeded MCO goals, the analysis showed the MY 2018 improvements were not statistically significant.</u></p> <p><b><u>The Follow-up for Mental Health PIP relates to access to behavioral health practitioners for follow-up.</u></b></p> <p><u>The 7-Day Follow-Up After Hospitalization for Mental Illness Remeasurement 4 rate (28.09%) decreased 4.39 percentage points compared to the Remeasurement 3 rate (32.48%), falling 5.91 percentage points below the MCO goal of 34%. The decrease in the rate, however, was not statistically significant. Due to changes in specifications impacting this reporting period, NCQA recommended a break trending.</u></p> <p><u>The 30-Day Follow-Up After Hospitalization for Mental Illness Remeasurement 4 rate (50.85%) decreased by 1.00 percentage point compared to the Remeasurement 3 rate (51.85%). The decrease was not significant. The MCO's goal (53.00%) was not met. As noted above, NCQA recommended a break trending results due to changes to performance measure specifications.</u></p> <p><u>The Engagement of AOD Treatment measure Remeasurement 2 rate (20.82%) increased 2.78 percentage points compared to the Remeasurement 1 rate (18.03%). The MCO exceeded its goal (20%) by 0.82 percentage points, and the increase was statistically significant.</u></p> <p><u>Thus, MCO reevaluating options with how to enhance engagement from both providers and beneficiaries with regard to these indicators. In addition, as the quality strategy retired the screening for clinical depression and follow-up measure, the MCO has added an indicator relating to the engagement of alcohol and other drug treatment which the baseline rate shows 17.32%.</u></p> |
| <p>Problems Identified</p>                          |   |
| <p>Corrective Action:<br/>(plan/provider level)</p> | <p><u>For both PIPs, MCO shall continue with strategies to improve measure rates which are aimed at providing education to both providers and beneficiaries. Along with determining ways in which to not only provide information but foster engagement with regard to diabetes or mental health. The related measures will continue to</u></p>   |

|  |   |
|--|---|
|  | <i>be monitored – as results are known, based on timing of HEDIS reporting, these will be provided to the State-MCO Quality Committee. In the meantime, the MCO will provide a report with regard to the implementation of interventions and applicable outcomes identified to the State-MCO Quality Committee a standing agenda item.</i>  |
| Program Change:<br>(system-wide level)   | <i>At this time the, State-Quality Committee plan to continue with current identified PIPs.</i>   |
| <b>STRATEGY</b>  | <b>Performance Measures</b>   |
| Confirmation (it was conducted as described):<br><input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO – Please Explain |   |
| Summary of Results:  | <p><i>The on-site Independent Assessment performed by the EORO evaluated the performance measures as related to quality care which were required by ND DHS. These included several performance measures from the CMS Adult and Child Core Quality Sets along with some of the Prevention Quality Indicators from the Agency of Health Care Research and Quality (AHRQ).</i></p> <p><i>It was identified that the MCO had satisfactory process for data integration, data control, and interpretation of the measures. The MCO’s source code used to report measures was found to be acceptable and measures were determined to be reportable. The MCO performance results related to the performance measures can be found in Attachment E Appendix III.</i></p> <p><i>As compared to NCOA Quality Compass benchmarks, the MCO performed above average or exceeded on some of the selected performance measures. The MCO performed below the national averages on the following measures:</i></p> <ul style="list-style-type: none"> <li>➤ <i>Adult Performance Measures</i> <ul style="list-style-type: none"> <li>• <i>Breast Cancer Screening was 54.97% (4.53% increase since MY2016)</i></li> <li>• <i>Cervical Cancer Screening was 43.60% (11.76% increase since MY2016)</i></li> <li>• <i>Flu Vaccinations for Adults was 38.93% (1.26% increase since MY2016)</i></li> <li>• <i>Chlamydia Screening in Women, Upper Age Stratification (Ages 21-24) was 40.52% (1.53% increase since MY2016)</i></li> <li>• <i>Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days) was 28.11% (3.2% increase since MY2016)</i></li> <li>• <i>Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days) was 51.62% (4.56% increase since MY2016)</i></li> <li>• <i>Comprehensive Diabetes Care: Eye Exam was 51.12% (2.98% increase since MY2016)</i></li> </ul> </li> </ul> |

|   |   |
|---|---|
|   | <ul style="list-style-type: none"> <li>• <u>Annual Monitoring for Patients on Persistent Medications: For Enrollees on ACE Inhibitors or ARBs was 87.81% (3.37% increase since MY2016)</u></li> <li>➤ <u>Child Performance Measures – Ages 19 -20</u> <ul style="list-style-type: none"> <li>• <u>Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days) was 27.91% (12.28% increase since MY2017)</u></li> <li>• <u>Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days) was 44.19% (9.81% increase since MY2017)</u></li> </ul> </li> <li>➤ <u>Prevention Quality Indicator</u> <ul style="list-style-type: none"> <li>• <u>Diabetes Short-Term Complications Admission Rate (lower is better) was 40.85% (1.54% increase since MY2016; however 4.22% decrease since MY2017)</u></li> <li>• <u>Congestive Heart Failure Admission Rate (lower is better) was 29.07% (10.81 % increase since MY2016)</u></li> </ul> </li> </ul> |
| <p>Problems Identified</p>                          | <p><u>As noted above under Summary of results – the MCO performed below the national average on some of the performance measures as related to quality performance measures as related to quality care. While the identified measures performed below the national average, many of them have seen % increases. In particular, those associated with PIPs.</u></p>  |
| <p>Corrective Action:<br/>(plan/provider level)</p> | <p><u>MCO shall continue with strategies to improve measure rates which are aimed at providing education to both providers and beneficiaries. Updates will be provided to the State-MCO Quality Committee and if the performance in these measures continues to be a concern with the next collection of HEDIS data consideration will be given to the option of incorporating these into potential PIPs based on appropriateness for the population. At this time, State-Quality Committee prefers to continue focus on existing PIPs and once the trends associated with them have improved and stabilized will consider additional efforts geared toward other measures based on overall appropriateness for the population.</u></p>   |
| <p>Program Change:<br/>(system-wide level)</p>      |   |

## **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.

### **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: Eric Haas
- c. Telephone Number: 701.328.1281
- d. E-mail: ehaas@nd.gov
- e. The State is choosing to report waiver expenditures based on
  - date of payment.
  - date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

### **B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**

*Not Applicable*

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.

*Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

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

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

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

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

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

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

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

*Not Applicable*

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 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: *Not Applicable***

- 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.  [Required] Population in the base year and R1 and R2 data is the population under the waiver.

*R1 and R2 data reflects the population enrolled ND Medicaid Expansion through 09-30-2019.*

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

*R2 includes three quarters of actual payments and 9 months of actual enrollment.*

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

*Historically, the member months had grown by approximately 500 to 1,000 new members per month for the ND Medicaid Expansion 1915(b) waiver population throughout the years. At this time, the State is anticipating that we will end R2 at 21,600. As the State forecast for the ND Medicaid Expansion 1915(b) waiver population was 20,500 and other estimates were 32,000, along with this being the third renewal waiver, the State anticipates continued growth in enrollment numbers from month to month. This growth has likely stabilized and pertains to member changes within category of eligibility and new eligibility through*

enrollment periods. Thus, from R2 to P1 the State anticipates a 9.6% increase (125 new members per month) and this will change to a 7.2% (100 new members per month) increase from P1 to P2.

- d.  [Required] Explain any other variance in eligible member months from BY/R1 to P2: No other variances were noted in eligible member months from BY/RI to P2.
- e.  [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: Calendar Year for R1/R2.

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

### **For Initial Waivers:** Not Applicable

- 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.  [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**: \_\_\_\_\_

The State included all the alternative benefit plan services as indicated in the ND State Plan Amendment. As of January 1, 2020, services pertaining to medical benefits will be administered and managed through the MCO and services pertaining to pharmacy benefits will be administered and managed through the Department as fee-for-service Medicaid.

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

No excluded services

## **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:** Not Applicable

1. 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 |
|--|--|---------------------|--|
| <i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i> | \$54,264 savings or .03 PMPM             | 9.97% or \$5,411    | \$59,675 or .03 PMPM P1<br>\$62,488 or .03 PMPM P2 |
|  |  |                     |  |
|  |  |                     |  |
| <b>Total</b>   | Appendix D5 should reflect this.         |                     | Appendix D5 should reflect this.                   |

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

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

The State has direct and indirect administrative costs related to the ND Medicaid Expansion 1915(b) Waiver. The North Dakota Department of Human Services operates within a federally approved cost allocation plan. The Department currently maintains a specific Department ID within People Soft, the state’s accounting system, to accumulate all of the direct salaries, and operating costs related to Medicaid Expansion. The Department ID is also used to accumulate all allocated contract costs for services based upon information received from the contract vendor.

Medicaid Expansion contracts: Olarant Quality Solutions Inc , Inc. provides External Quality Review services these costs are directly charged to Medicaid Expansion.

Optumas provides actuarial services for department activities. These costs are allocated to the applicable activities based upon the actual hours worked by the provider for each activity.

Health Information Designs, LLC (HDI) provides drug rebate services for department activities. These costs are allocated to the applicable activities based upon the actual hours worked by the provider for each activity.

As the State moves forward with the design and build of including the ND Medicaid Expansion managed care population into the ND Health Enterprise MMIS, North Dakota will be using the cost allocation used for the ND Health Enterprise MMIS OAPD to allocate costs to the ND Medicaid Expansion 1915(b) waiver administrative costs.

In a letter dated November 4, 2015, CMS approved the OAPD for the North Dakota Health Enterprise MMIS, which included the allocation methodology for ND Health Enterprise MMIS operations. The language approved in the MMIS OAPD is as follows:

Expenditures related to the MMIS Health Enterprise system will be allocated to programs using the accumulated number of transactional claim numbers paid for each program from MMIS and accumulated federal fiscal year to date each month.

Following the approved method for allocating costs, actual federal fiscal year 2016 expenditures will be allocated to each program from MMIS based on actual FFY2016 accumulated transactional claim numbers paid. The amounts and allocations included in this OAPD are estimates based on efforts needed to maintain and support the system and FFY2015 paid claims data, which is our current federally approved method used to allocate costs.

We estimated for the 1915(b) waiver that the actual accumulated transactional claim numbers paid will be approximately 10.77%.

## **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**

| <b>1915(b)(3) Service</b>   | <b>Savings projected in State Plan Services</b>                            | <b>Inflation projected</b> | <b>Amount projected to be spent in Prospective Period</b>                  |
|---|--|----------------------------|--|
| <i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i> | \$54,264 savings or .03 PMPM   | 9.97% or \$5,411           | \$59,675 or .03 PMPM P1<br>\$62,488 or .03 PMPM P2                         |
| <b>Total</b>  | (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**

| <b>1915(b)(3) Service</b>   | <b>Amount Spent in Retrospective Period</b>     | <b>Inflation projected</b> | <b>Amount projected to be spent in Prospective Period</b> |
|---|---|----------------------------|---|
| <i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See</i> | \$1,751,500 or \$1,97 PMPM R1<br>\$1,959,150 or | 8.6% or \$169,245          | \$2,128,395 or 1.07 PMPM in P1                            |

|  |  |  |  |
|--|--|--|--|
| <i>attached documentation for justification of savings.)</i> | <i>\$1.04 PMPM R2 or BY in Conversion</i>                        |  | <i>\$2,291,216 or 1.10 PMPM in P2</i>                                      |
|  |  |  |  |
| <b>Total</b>   | (PMPM in Appendix D3 Column H x member months should correspond) |  | (PMPM in Appendix D5 Column W x projected member months should correspond) |

- b.  The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- c.  Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCO(s)/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCO(s)/PIHPs/PAHPs when MCO(s)/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 stop/loss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.  The State does not provide stop/loss protection for MCO(s)/PIHPs/PAHPs, but requires MCO(s)/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 MCO(s)/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 MCO(s)/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

*Not Applicable – Skip to Section J*

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 rate setting 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):
  - FFS cost increases were accounted for. 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.  [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.  
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 MCO(s)/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 MCO(s)/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.  [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).  
The actual trend rate used is:  
Please document how that trend was calculated:
2.  [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting 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 CY2018-CY2019. 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.

The State utilizes contracted actuary services to calculate rates for the ND Medicaid Expansion 1915(b) waiver population. Optumas set the rates for CY 2018 and CY 2019 ensuring that the methodology used to develop the rate changes complied with the Center of Medicare & Medicaid Services (CMS) guidance for the development of actuarially sound rate ranges. Based on the historical rate increases experienced in R1 and R2, the State anticipates that these will continue to increase by 11% during P1 and 8% during P2. The 11% during P1 includes the anticipated 3% associated with the Health Insurance Provider Fee which is applicable for CY2020.

In addition, the utilization of this program was based on the state's projections that between 20,5000 and 32,000 individuals may be eligible for ND Medicaid Expansion which the state anticipates continued growth in member months. The growth throughout P1 and P2 will likely be stabilized with a constant rate of growth in relation to member changes with regard to category of eligibility and new eligibility through enrollment periods.

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

3. \_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

**b. State Plan Services Programmatic/Policy/Pricing Change Adjustment:**

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is

changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

A. \_\_\_ 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.

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

- i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ ***Determine adjustment for Medicare Part D dual eligibles.***
  - E. \_\_\_ Other (please describe):
- ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. \_\_\_ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs).  
Please explain:
- iv. \_\_\_ Changes brought about by legal action (please describe):  
For each change, please report the following:

- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
- B. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
- C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
- D. \_\_\_ Other (please describe):
- v. \_\_\_ Changes in legislation (please describe):  
For each change, please report the following:
  - C. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
  - E. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - F. \_\_\_ 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): *Services pertaining to pharmacy benefits remain within the Alternative Benefit Plan; however, expenditures pertaining to these services will shift from being with in the capitation rate and will be fee-for-services as those services will be administered and managed by the Department through fee-for-service Medicaid. For both P1 and P2 a -0.3% program adjustment was applied in relation to services pertaining to the transition of pharmacy benefits delivery. This program adjustment accounts for anticipated efficiencies with utilization and authorization associated with use of State's Preferred Drug List.*
- c. **Administrative Cost Adjustment:**

This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.*

  - 1. \_\_\_ No adjustment was necessary and no change is anticipated.

2.  An administrative adjustment was made.
- i.  Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:  
*Services pertaining to pharmacy benefits remain within the Alternative Benefit Plan; however, expenditures pertaining to these services will shift from being within the capitation rate and will be fee-for-services as those services will be administered and managed by the Department through fee-for-service Medicaid. For P1 and P2 factored in a program adjustment for anticipated efficiencies with utilization and authorization associated with the use of the State's Drug Preferred Drug List (as noted above); however, with the transition of the pharmacy administrative functions to the Department, associated expenditures of system implementation and increase contract expense pertaining to HDI need to be factored in.*
- ii.  Cost increases were accounted for.
- A.  Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
- B.  Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C.  State Historical State Administrative Inflation. The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:
- D.  Other (please describe):
- The State anticipates that administrative cost for P1 will be 6% and P2 will be 3%. P1 and P2 administrative costs are higher than the R2 due to the following:*
- Renewing the EORO contract for July 2019 through June 2021*
  - Anticipating that the actuarial service costs will be slightly increased over P1 due to the need to re-evaluate 2019 rates for actuarial soundness in relation to implementation of 1915(i) Waiver as of July 1, 2020..*
  - Services pertaining to pharmacy benefits being administered and managed by the Department as fee-for-service Medicaid; thus, have initial expenditures associated with system implementation and increase contract expense pertaining to HDI.*
- 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:** *Not Applicable*

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:** *Not Applicable*

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. X Other (please describe):  
R2 costs were adjusted down by approximately 0.5% in P1 and 0.5% in P2.
1. \_\_\_ No adjustment was made.
  2. X This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.  
The State is continuing to average \$4 million in drug rebates with approximately \$60 million of expenditures in a quarter. For P1 and P2 the drug rebate adjustment remains stable at 0.5% to account for additional growth in beneficiaries. This adjustment was made in Tab D5 Column L Row 13 and 30.

### **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.

See Section D.I.J

### **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.

See Section D.I.E

### **M. Appendix D7 - Summary**

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

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

Member months are increased from R2 to P1 through P2 based on the State forecasts for the ND Medicaid Expansion 1915(b) waiver population (20,500 to 32,000) and it being the thirdwaiver renewal for this program in which the State anticipates continued growth. The growth throughout P1 and P2 will likely be stabilized with a constant rate of growth in relation to member changes with regard to category of eligibility and new eligibility through enrollment periods

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**:

Unit costs changes are a component of the trend adjustments described in Section D.I.J. The State chose to calculate its expected trends on a PMPM basis rather than to separate the trend into utilization and unit cost components.

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**:

Utilization costs changes are a component of the trend adjustments described in Section D.I.J. The State chose to calculate its expected trends on a PMPM basis rather than to separate the trend into utilization and unit cost components.

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.*