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

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

The **name of the waiver program** is _____ ***MyCare Ohio, Ohio's Integrated Care Delivery System (ICDS) Demonstration***_____. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

_ __ initial request for new waiver. All sections are filled.

_X __ amendment request for existing waiver, which modifies Section C Enrollment and Disenrollment to include language stating that a member who is in a Medicare Part D drug management program and is in a potentially at-risk or at-risk status as defined in 42 C.F.R. 423.100 is precluded from changing plans.

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

_X_ Document is replaced in full, with changes highlighted

_ __ renewal request

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

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

Section A is ___ replaced in full

_ __ carried over from previous waiver period. The State:

__ _ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

_ __ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

_ __ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested; effective _____ ***January 1, 2020***____and ending ____***December 31, 2023*** _____. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is ___ ***Roxanne Richardson***_____ and can be reached by telephone at ***614.752.0503***, or fax at ***614.752.7701***, or e-mail at ***Roxanne.Richardson@medicaid.ohio.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.

Response: There are no federally recognized tribes in the State of Ohio.

Program History
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Background

Over 182,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to one another. With no single point of accountability, long term care services and supports, behavioral health services, and physical health services are poorly coordinated. The result is diminished quality of care for Medicare-Medicaid enrollees and unnecessarily high costs for taxpayers.

As part of the effort to address these issues in the Medicaid program, the State of Ohio is requesting a 1915(b) waiver in order to allow for the mandatory enrollment of individuals 18 years old and older who are eligible for Medicare and Medicaid into managed care. The 1915(b) waiver will operate concurrently with a new 1915(c) waiver to provide the full array of Medicaid benefits to beneficiaries. The 1915(c) waiver request was submitted simultaneously to CMS for their review and approval. Ohio received approval by CMS on July 15, 2013 (OH.1035) for an effective date of April 1, 2014 for the 1915(b) waiver for a five-year waiver term, ending March 31, 2019.

Ohio has been selected as one of the Centers for Medicare and Medicaid Services (CMS) Duals Demonstration programs. Through the CMS Medicare-Medicaid Demonstration program, Ohio is developing a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including Long Term Services and Supports (LTSS). Medicare-Medicaid beneficiaries will be served by MyCare Ohio Plans in selected regions across the state. Passive enrollment continues on a monthly

basis as consumers become eligible and open enrollment occurs annually in November.

Under the ICDS Demonstration, Ohio competitively selected ICDS Plans to manage a comprehensive benefit package for Medicare-Medicaid enrollees, utilizing a variety of care management tools to ensure that services are coordinated. These ICDS plans will operate as the managed care organizations (MCOs) and provide the Medicaid managed care services under the 1915(b) waiver. The ICDS plans will:

- ***Arrange for care and services by specialists, hospitals, and providers of LTSS and other non- Medicaid community-based services and supports;***

- ***Allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services;***

- ***Cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals;***

- ***Use a person-centered care coordination model that promotes an individual's ability to live independently through a process that emphasizes the role of the individual in the development of their care plan; and***

- ***Utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.***

Ohio anticipates that the savings achieved through the ICDS Demonstration will enable more Medicare-Medicaid enrollees to receive the medical and long-term services and supports they need in their own homes and other community-based settings, rather than in more costly institutional settings. Ohio will demonstrate that its model of integrated care and financing will:

- ***Keep people living in the community;***
- ***Increase individuals' independence;***
- ***Improve the delivery of quality care;***
- ***Reduce health disparities across all populations;***
- ***Improve health and functional outcomes;***
- ***Reduce costs for individuals by reducing or avoiding preventable hospital stays, nursing facility admissions, emergency room utilization; and***
- ***Improve transitions across care settings.***

Ohio requested approval through the 1915(b) waiver to implement a geographic phase-in for enrollment by county over a period of three (3) months, in order to

furnish services to those individuals who reside in following counties: Fulton, Lucas, Ottawa, Wood, Lorain, Cuyahoga, Lake, Geauga, Medina, Summit, Portage, Stark, Wayne, Trumbull, Mahoning, Columbiana, Union, Delaware, Franklin, Pickaway, Madison, Clark, Greene, Montgomery, Butler, Warren, Clinton, Hamilton and Clermont.

The concurrent 1915(c) waiver permits Ohio to provide home and community-based services (HCBS) that are not otherwise available through the Medicaid state plan to individuals who are eligible for the ICDS demonstration and require a nursing facility (NF) level of care (LOC).

Ohio's 1915(i) state plan amendment (SPA)TN# 15-0014 will permit Ohio to provide Individual Placement and Support – Supported Employment (IPS-SE), Peer Recovery Support, and Recovery Management services (performed by Conflict Free Case Management Agencies) to individuals who are concurrently eligible for the 1915(i) program and the ICDS demonstration through the MyCare MCPs.

In addition to providing the essential authority for individuals participating in the ICDS demonstration, the 1915(b) waiver also serves eligible individuals who have elected to opt-out of the demonstration.

<u>Enrollment</u>

Medicare-Medicaid beneficiaries living in the covered geographic area who do not choose a MyCare Ohio Plan are passively enrolled in a MyCare Ohio Plan. For purposes of this waiver, these beneficiaries are referred to as "opt-in" beneficiaries. The beneficiary may "opt-out" of the MyCare Ohio Plan for Medicare-covered benefits, but will be mandatorily enrolled after the 60 day choice period for Medicaid-covered benefits. The 1915(b) waiver covers eligible individuals who have elected to "opt-out" of the Medicare portion of the ICDS Demonstration. Individuals who "opt-out" may re-enroll in the MyCare Ohio Plan at any time.

Medicare-Medicaid enrollees in the targeted geographic regions are notified of their selection for the MyCare Ohio program. Not less than 60 days prior to enrollment into the MyCare Ohio program, a letter of notification informs individuals that they will be enrolled in their plan of choice for both their Medicaid-covered benefits and their Medicare-covered benefits. If the individual does not choose a MyCare Ohio plan, the individual will be auto-enrolled into one of the plans.

Individuals may re-enroll in the Medicare component of the ICDS Demonstration at any time upon request. If eligible participants elect to opt-out of the MyCare

Ohio Plan for their Medicare-covered benefits, they remain enrolled in the MyCare Ohio Plan for their Medicaid-covered services.

The population eligible to enroll in MyCare Ohio Plans is limited to "Full Benefit" Medicare-Medicaid enrollees only. Individuals who are only eligible for Medicare Savings Program benefits (QMB-only, SLMB-only, and QI-1) will not be eligible. Additionally, the following specified populations are excluded from participating in the ICDS program and excluded from the MyCare 1915(b) Waiver program:

- ***Individuals with Intellectual Disabilities (IID) and other Developmental Disabilities (DD) who receive services through a 1915(c) HCBS waiver administered by Ohio Department of Developmental Disabilities or reside in an ICF-IID facility; Individuals enrolled in PACE;***
- ***Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage;***
  Individuals under the age of 18;

Based on the eligibility criteria stated above and the regions that are being proposed, Ohio estimates that 114,972 Medicare-Medicaid enrollees will be eligible to participate in the ICDS Demonstration.

<u>Community and Stakeholder Involvement</u>

Ohio has been working with stakeholders on the development of the ICDS Demonstration since January 2011. In doing so, the State has conducted numerous activities to solicit input and has considered stakeholders' concerns and expectations in making key decisions. These activities have included:

- ***A Request for Information (RFI) and summary of responses.***
- ***Testimony by the Ohio Medicaid Director before the Ohio Legislature.***
- ***Establishment of an advisory group made up of internal and external stakeholders.***
- ***Presentation of a concept paper to the State's Unified Long Term Care Systems Advisory Workgroup.***
- ***Regional meetings around the state, statewide conference calls, public hearings and a teleconference with individuals, family caregivers and advocates and stakeholders.***
- ***Development of a Q & A document and fact sheet associated with the ICDS concept paper.***
- ***Development of an individual questionnaire and summary of responses.***

- ***Links to key information about ICDS and stakeholder engagement activities on the Governor's Office of Health Transformation website.***
- ***Ongoing quarterly meetings with the MyCare Ohio Implementation Team (MCOIT).***
- ***Ongoing quarterly meetings with the Nursing Facility Collaborative.***
- ***Regularly scheduled meetings with public children services agency (PCSA), county department of job and family services staff (CDJFS) and other community stakeholders involved with IV-E foster/adoption children and children in out of home placements.***
- ***Regularly scheduled meetings with the behavioral health community representing providers and consumers regarding the 1915(i) SPA and enrollment in MyCare Ohio plans.***

Additionally, Ohio had previously convened a group of individuals, providers and stakeholders to discuss other waiver reform initiatives. The populations included in the ICDS Waiver are represented by this workgroup. As a result, the State will also use this forum to share and discuss the delivery of managed care and HCBS services in the ICDS demonstration.

Ohio will continue to engage with and incorporate feedback from stakeholders listed above in the Community and Stakeholder Involvement section, during the implementation and operational phases of the ICDS demonstration, including the ICDS 1915(b)(c) concurrent Waiver.

<u>Conclusion</u>
As part of Ohio's due diligence with including dual eligible individuals in a mandatory managed care program as permitted by ORC 5111.16, the state of Ohio assessed the managed care program objectives and affirmed the original goals of the program as appropriate to meet not only the needs of the dual eligible population but also the agency's responsibility as a public payer. Those objectives include:

- ***Accountability for access to and quality of care;***
- ***Improved access to primary and preventive care in the most appropriate settings;***
- ***Utilization management to assure appropriate use of services and minimize unnecessary use of specialty care, the emergency room, or inpatient services;***
- ***Enhanced member services and education;***
- ***Availability of information to assess program performance and plan future development;***
- ***Maximum cost predictability and administrative simplicity;***
- ***Improved health care coordination and health outcomes; and***

- ***Promotion of evidence-based prevention and treatment practices.***

The ICDS 1915(b) waiver will be administered by the Ohio Department of Medicaid (ODM), more specifically, the Office of Managed Care.

Please note: The State of Ohio refers to the ICDS managed care organizations as "MyCare Ohio Plans" in our responses to the 1915(b) pre-print questions.

ODM is requesting amendment of the MyCare (ICDS) waiver beginning January 1, 2020 through December 31, 2023 to enroll dual eligible individuals, in the designated counties, in managed care. Continuing with the objectives listed above and providing care coordination/coordination of services to dual eligible individuals.

A. Statutory Authority

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

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

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

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

d. ___ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

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

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

a._X_ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

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

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

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

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

B. Delivery Systems

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

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

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

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

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

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

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

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

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

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

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

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

1. **Assurances.**

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

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

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

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

3. **Rural Exception.**

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

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

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

D. Geographic Areas Served by the Waiver

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

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

_X__ **Less than Statewide**

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Central	***MCO***	***Aetna & Molina***
East Central	***MCO***	***CareSource & United***
Northeast	***MCO***	***Buckeye, CareSource & United***
Northeast Central	***MCO***	***CareSource & United***
Northwest	***MCO***	***Aetna & Buckeye***
Southwest	***MCO***	***Aetna & Molina***
West Central	***MCO***	***Buckeye & Molina***

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Low Income Subsidy (LIS) passive enrollment beginning April 1, 2014: Passive Enrollment for enrollees who otherwise are included in Medicare reassignment effective January 1, 2013 or from their current (2012) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will be eligible for passive enrollment into an ICDS Plan effective April 1, 2014. Passive enrollment continues on a monthly basis as consumers become eligible and open enrollment occurs annually in November.

E. Populations Included in Waiver

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

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

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

_X__ Mandatory enrollment [***for children age 18 or older]***
___ Voluntary enrollment

_X_ Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

__X_ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment
___ Voluntary enrollment

_ __ 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

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

_X__ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment [***effective January 1, 2017 for children 18 and older***]

___ Voluntary enrollment

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

_X__ Mandatory enrollment***[for children age 18 or older]***

___ Voluntary enrollment

__X__FORMER FOSTER CHILDREN described in section 1902(a)(10)(A)(i)(IX) of the Social Security Act.

__X__ Mandatory 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))

_X__ 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. ***[Children under the age of 18 are excluded]***

_X __ 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.

_X_ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition. [***As noted below in A.1.E.3, all children under the age of 18 are excluded from enrollment in MyCare Ohio Plans]*** Effective 1/1/2017, the State is adding the Bureau of Children with Medical Handicaps - BCMH (ages 18-22) populations who otherwise meet the qualifications of the MyCare program to the MyCare program.

_X__ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program. [***children under the age of 18]***

_ _ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

_X__ **Other** (Please define): ***See below***

3. Additional Detail

The population that will be eligible to participate in the MyCare Ohio program is limited to "Full Benefit" Medicare-Medicaid enrollees only, eligible for Medicare Parts A, B and D and full Medicaid in ICDS Demonstration Counties. Individuals who are only eligible for Medicare Savings Program benefits (QMB-only, SLMB-only, and QI-1) will not be eligible.

Additionally, the following specified populations will be excluded from enrollment in the MyCare Ohio 1915(b) waiver program, except when otherwise noted:

- ***Individuals with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who receive services through a 1915(c) HCBS waiver administered by Ohio Department of Developmental Disabilities or reside in an ICF-IID facility.***
- ***Individuals enrolled in PACE;***
- ***Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage; and***
- ***Individuals under the age of 18***

F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

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

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

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

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

___ Family planning services are not included under the waiver.

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

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
___ 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:

_X__The program is **mandatory** and the enrollee has the right to obtain FQHC services in and out of the MCO's network.

5. **EPSDT Requirements.**

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

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

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

7. **Self-referrals.**

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

FQHC/RHC services

Family planning services

8. Additional Detail for Services

Ohio has a concurrent 1915(c) waiver (OH.1035) for beneficiaries with a NF level of care (LOC).

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

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

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

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

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

Care management services will be available to all MyCare Ohio enrollees such that all are considered to have complex needs. Plans are expected to develop and implement comprehensive care management programs that address the following components: an identification strategy to prioritize the timeframe by which enrollees will receive an initial assessment; risk or acuity stratification assignment strategy; completion of an assessment; development, implementation and monitoring of an individualized care plan; and

formulation of a trans-disciplinary care management team to manage the enrollee's needs.

The MyCare Ohio Plans are responsible for developing and implementing an identification strategy that uses multiple mechanisms, such as predictive-modeling software, health risk assessment tools, functional assessments, referrals, or administrative claims data. The MyCare Ohio Plans' identification strategy will consider medical, mental health, substance use, long term care and social needs. Criteria and thresholds will be established in order to prioritize the timeframe by which enrollees will receive a timely initial assessment.

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

Each enrollee will receive, and be an active participant in, a timely assessment appropriate for the enrollee's unique needs. The scope and depth of the Assessment will vary based on the enrollee's assigned risk level. For enrollees in the low or monitoring stratification levels, a Health Risk Assessment may be completed. The Health Risk Assessment must address self-assessment of health status and physical functioning, psychosocial risks, and behavioral risks. Other age-appropriate domains should also be included. Enrollees assigned to all other risk stratifications must have a Comprehensive Assessment including, but not limited to, social, functional, medical, behavioral, long term services and supports, wellness and prevention domains, caregiver status and capabilities, as well as the enrollees' preferences, strengths and goals. Relevant and comprehensive data sources, including the enrollee, providers, family/caregivers, medical record data, and claims will be used to complete the assessment. Results of the assessment will be used to confirm the appropriate acuity or risk stratification level for the enrollee and as the basis for developing an integrated, individualized care plan.

Upon enrollment in a MyCare Ohio plan, all enrollees will receive an assessment that will be completed no later than 75 days from the individual's enrollment date. An assessment will be completed at least once every 12 months after the initial assessment completion date. Assessments will be updated when there is a change to the enrollee's health status or needs, a significant health event (e.g.,

hospital admission or transition between care settings), or as requested by an enrollee, his/her caregiver, or his/her provider.

Initial assessments and annual reassessments will be completed in person for the highest risk enrollees and for all enrollees receiving 1915(c) home and community based waiver services. Initial assessments and annual reassessments will be completed telephonically for enrollees assigned to the monitoring, low or medium risk levels unless an in person assessment is requested by the enrollee, caregiver, or provider.

Assessments will be completed by qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the enrollee's needs. Examples of health professionals who may complete portions or all of the assessment include registered nurses, licensed practical nurses (under supervision of a registered nurse), social workers, mental health counselors, or community health workers.

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

1.X_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

A person-centered, individualized, integrated care plan will be developed by the Plan's trans-disciplinary care management team (i.e., team of professionals led by the accountable care manager to ensure the integration of the enrollee's medical, behavioral health, substance use, LTSS and social needs) with the enrollee, his/her family members/supports, and providers that addresses all of the clinical and non-clinical needs of the enrollee, including integration of the waiver service plan, as appropriate, and as identified in the comprehensive assessment. Care plans will contain measureable goals, interventions, and expected outcomes with completion timeframes.

2._X_ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

The MyCare Ohio Plan's accountable care manager, who leads the trans-disciplinary care management team, will approve the care plan that is implemented and monitored by the team. Continuous monitoring of the care plan will occur and any gaps in care will be addressed in an integrated manner by the team including any revisions to the care plan.

The initial care plan will be developed and implemented in a timeframe that is commensurate to the enrollee's needs but no later than 90 days from the enrollee's start date with the Plan. For enrollees with waiver service plans, the Plan must consider how timeframes for waiver service plan development and monitoring will impact the development of the comprehensive care plan. For those individuals who are eligible for the 1915(i) state plan amendment services, the care plan will include the relevant services that the individuals are receiving.

3._X_ In accord with any applicable State quality assurance and utilization review standards.

MyCare Ohio Plans will be expected to develop and implement a care planning process that yields an individualized care plan, is based on the comprehensive assessment, and includes minimum components as specified by the State in the Provider Agreement. Plans shall consider the Case Management Society of America's Standards of Practice for Case Management (2016) in the development and implementation of their care management programs. The State will also review and approve the Plan's care management programs to ensure that all required components specified in the Provider Agreement are adequately addressed.

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

All MyCare Ohio Plans will allow enrollees to directly access in network specialists without referrals; however, Plans may encourage enrollees to inform their primary care providers of specialist visits for coordination of care purposes. Referrals to specialists shall be documented in the plan of care to allow the Plan to follow up on the referral and coordinate care as necessary.

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

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

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

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

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

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

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

_X__ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on <<<_>>>***. March 28, 2003 under a previous 1915(b) waiver for Medicaid managed care programs with revisions submitted in March 2008 and May 2010. The State submitted the Managed Care Quality Strategy to CMS pursuant to 42 CFR 438.340 in June 2018.***.

X__ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities

MCO	***Health Services Advisory Group***		***-Validation of Performance Improvement Projects -Validation of Performance Measures -Administrative compliance assessment***	***-Validation of encounter data studies -Consumer satisfaction surveys -Information Systems Reviews***
PIHP				

2. **Assurances For PAHP program.**

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

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

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

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

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

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

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

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

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

MyCare Ohio Plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and

media and billboard advertisements), and provide responses to beneficiary initiated requests for enrollment information.

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

ODM permits MyCare Ohio Plans to send mailings to potential beneficiaries upon ODM approval. ODM will follow a blinded process that safeguards client confidentiality. ODM only permits MyCare Ohio Plans to make person-to-person marketing presentations when they have been requested by the beneficiary.

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

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

MyCare Ohio Plans cannot offer material or financial gain as an inducement to enroll. ICDS Plans can provide nominal gifts as long as the gifts are prior-approved by ODM and offered whether or not the eligible individual enrolls in the ICDS plans. The State monitors this through the prior-approval process.

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

All ICDS marketing representatives must be employees of the ICDS Plan. No more than 50% of a marketing representative's total annual compensation may be paid on a commission basis. ODM reserves the right to review all compensation packages for marketing representatives as its assurance of compliance with this requirement.

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

The 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._X_ The languages comprise all languages in the service area spoken by approximately __**5**_ percent or more of the population.

iii.__ Other (please explain):

ODM requires MyCare Ohio Plans to provide written translation of marketing materials if 5% or more of eligible individuals in the ICDS Plan's service area have a primary language other than English in their service area.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

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

1.___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. _X_ The languages spoken by approximately **_5__** percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

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

ICDS Plans and the enrollment broker (Ohio Medicaid Consumer Hotline) assure access to oral translation services through use of language line services and interpreters. Language line services are available 24 hours a day, 7 days a week.

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

The State as well as its enrollment broker (Ohio Medicaid Consumer Hotline) will provide factual and unbiased information regarding available ICDS Plans to enrollees and potential enrollees. Every eligible enrollee is provided the basic information about managed care and enrollee rights and protections as required in 42 CFR 438.10. Potential enrollees and enrollees can also call, e-mail or write to the state or enrollment broker with questions and concerns about the managed care program.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X__ State

_X__ contractor (please specify) ___***Automated Health Systems, Inc.***_____

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

c. Enrollee Information

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

(i) _X_ the State

(ii) _X__ State contractor (please specify):__***Automated Health Systems, Inc.***_____

(ii) __X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider ***MCO***

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

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

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

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

The State sends a notice of mandatory enrollment which advises eligible individuals of the requirement to enroll in a MyCare plan, excepted populations, and how to obtain additional information. The Hotline sends a reminder notice informing enrollees of passive enrollment and the name of their assigned ICDS plan if the enrollee does not make an active selection. The Hotline also conducts a call campaign informing eligible individuals of their assigned plan, the ability to change plans, and provides additional choice counseling upon request at that time.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

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

__X_ 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: **Automated Health Systems, Inc.**

Please list the functions that the contractor will perform:

_X__ choice counseling
_X__ enrollment
_X_ other (please describe):

Provision of enrollment opportunities by phone, by mail, or online.

- ***Participation in meetings with stakeholders and interested parties.***

- ***Assignment of those eligibles in ICDS demonstration counties that do not voluntarily choose an ICDS plan within the time allotted on the State-generated and mailed Notice of Mandatory Enrollment, or NME.***

- ***Completion of enrollee-initiated Medicare opt-out requests.***

- ***Reporting, both statistical and narrative of all Contractor activities on a biweekly basis.***

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

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

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

Passive enrollment occurs on a monthly basis as individuals become eligible for the ICDS demonstration program and open enrollment occurs annually in November.

<u>Low Income Subsidy (LIS) passive enrollment:</u> Passive enrollment for enrollees who are eligible for LIS and are otherwise included in Medicare reassignment effective January 1 of each year will be eligible for passive enrollment into an ICDS Plan effective January 1 of each year.

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

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

i. _X__ Potential enrollees will have_***60***___days/month(s) to choose a plan.

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

The State utilizes an assignment algorithm for passive enrollment that compares historical providers utilization in order to prioritize continuity of providers and/or services.

The auto-assignment algorithm is first based on the existing MA plan or MyCare Ohio plan enrollment with the goal of preserving the existing provider-patient relationships.

The auto-assignment process assigns the enrollee to the MyCare Ohio plan that has the most provider visits and the highest number of provider network matches. If there is no existing relationship with a provider, the individual is assigned to a MyCare plan based on a round robin methodology. Enrollees will not be assigned to MyCare plans that have been sanctioned.

___ The State **automatically enrolls** beneficiaries

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

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

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

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

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

_X__ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 3 months or less.

d. **Disenrollment:**

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

i._X__ Enrollee submits request to State.

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

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

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

_ X__ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of **_12__** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):_____

For enrollees that opt-out of the ICDS demonstration, just cause reasons include the following:

(i) The member moves out of the ICDS Plan's service area and a non-emergency service must be provided out of the service area before the effective date of the member's automatic termination.

(ii) The ICDS Plan does not, for moral or religious objections, cover the service the member seeks.

(iii) The member needs related services to be performed at the same time; not all related services are available within the ICDS Plan network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk.

(iv) The member would have to change their residential, institutional, or employment supports provider based on the provider changing from an in-network to out-of- network provider.

(v) Poor quality of care and the services are not available from another provider within the ICDS Plan's network.

(vi)Lack of access to medically necessary Medicaid-covered services or lack of access to the type of providers experienced in dealing with the member's health care needs.

(vii) The PCP selected by a member leaves the ICDS Plan's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another ICDS Plan in the member's service area.

(viii) A situation in which, as determined by ODM, continued membership in the ICDS Plan would be harmful to the interests of the member.

For opt-in enrollees in the ICDS demonstration, disenrollment (opt-out) from MyCare plans and transfers between MyCare plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. Enrollment in the Medicaid portion of MyCare is mandatory.

A member who is in a Medicare Part D drug management program and is in a potentially at-risk or at-risk status as defined in 42 C.F.R. 423.100 is precluded from changing plans.

_ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without

cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

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

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

(a) Fraudulent behavior by the member; or
(b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the ICDS Plan's ability to provide services to either the member or other ICDS Plan members.

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

E. Grievance System

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

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

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

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

_X__ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing in accordance with 42 C.F.R. 438.402.

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

b. **Timeframes**

__X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **60__** days in accordance with 42 C.F.R. 438.402.

_X__ The State's timeframe within which an enrollee may file a **grievance** at any time in accordance with 42 C.F.R. 438.402.

c. **Special Needs**

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

ICDS Plans are required to provide additional assistance to hearing-impaired, vision-impaired, limited-reading proficient and limited-English proficient members.

4. **<u>Optional grievance systems for PCCM and PAHP programs</u>**. 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 procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

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

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

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (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.**

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

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X__ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

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

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

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

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

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

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

Additional detail:

Pursuant to 42 CFR 455.20, MyCare Ohio plans must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MyCare Ohio plan is required to conduct a mailing of Explanation of Benefits (EOB) to a 95% confidence level (plus or minus 5 percent margin of error) sample of the MyCare Ohio plan's enrollees once a year. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding the release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MyCare Ohio plan. MyCare Ohio plans must inform their Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies). This annual EOB mailing (which would include waiver services and any 1915(i) SPA services) is a tool for the state to gather information from consumers to verify/report if services are not received.

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Eva
	Choice	Marketing	Enroll/ Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Authorization
Accreditation for Non-duplication							X	X	X	X
Accreditation for Participation										
Consumer Self-Report data					X	X	X	X	X	
Data Analysis (non-claims)			X			X	X	X	X	X
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			X		
Ombudsman	X	X			X		X		X	
On-Site Review		X		X	X	X	X	X	X	X
Performance Improvement Projects							X		X	
Performance Measures							X		X	
Periodic Comparison of # of Providers										
Profile Utilization by Provider Caseload										

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Eva
	Choice	Marketing	Enroll/ Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Authorization
Provider Self-Report Data								X		X
Test 24/7 PCP Availability										
Utilization Review										
Other: (describe)										

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. __X__ 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)

_X__ NCQA
___ JCAHO
___ AAAHC
_X__ Other (please describe): Centers for Medicare and Medicaid Services (CMS)

- ***Applicable Programs: MCO***

- ***Personnel responsible: State Medicaid, CMS, EQRO***

- ***Detailed description of activity: ODM uses the EQRO to evaluate managed care plan compliance with access, structure and operation, and quality improvement standards as required by 42 CFR 438.358. As permitted by 42 CFR 438.360, ODM uses reviews completed by a private accrediting body (i.e., NCQA and URAC) or CMS for standards, as applicable, that are as stringent as those required in 42 CFR 438 Subpart D. Using a crosswalk, ODM's contracted EQRO identified the Medicaid CFRs that are eligible for non-duplication and that are 100% comparable to URAC, NCQA or Medicare standards.***

  Information from private accreditation reviews - To ensure Plan compliance with CMS regulations, and for the related standard to be exempt from review by the EQRO, the Plan's score on the accreditation standard/element must be 100 percent of the point value during the Plan's most recent NCQA or URAC accreditation survey (within the recent 3 year period). The EQRO will review the Plan's most recent NCQA or URAC accreditation survey and determine which of the elements can be excluded from the review based on the Plan's score on the related standard. Deemed standards will be designated as "met" on the standardized data collection tool that will be used for the administrative compliance assessment.

Information from CMS Medicare reviews – The State will use information from CMS Medicare reviews, as applicable, in order to avoid duplication of required external quality review activities.

- ***Frequency of use: Information from the deeming review will be used as part of the administrative compliance assessments that are performed once in a three year period to comply with 42 CFR 438.358.***

- ***How it yields information about the areas being monitored: Information from these reviews will be used to monitor standards established for: timely access, PCP/specialist capacity, coordination/continuity, coverage and authorization, and provider selection (i.e., areas where there has been substantial overlap between private accreditation standards and CMS Medicaid managed care regulations). As a result of the administrative compliance assessment, the EQRO will produce a comprehensive report of findings for each MyCare Ohio plan that will indicate if the Plan meets/does not meet the standard under review. If the Plan is non-compliant with a standard, at a minimum, the Plan will be required to implement a corrective action plan to remedy the deficiency.***

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

_X_ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

- ***Applicable Programs: MCO***

- ***Personnel Responsible: State Medicaid, MCO***

- ***Detailed description of activity:***

  Accreditation will not be required as a pre-requisite to be a MyCare Ohio plan. MyCare Ohio Plans will instead be required to hold and maintain, or must actively seek and work towards, accreditation by the National Committee for Quality Assurance for the Ohio Medicaid or Medicare lines of business.

Once accredited, the Plans will be required to submit a copy of the NCQA final survey report to ODM. Based on the survey report, ODM will evaluate if the plan received an acceptable level of accreditation as required in the Provider Agreement. If the Plan does not meet the minimum performance standard, the Plan will be subject to penalties. NCQA accreditation ratings are posted on the publicly facing ODM website, Medicaid.ohio.gov.

- ***Frequency of activity: Annual***

- ***How it yields information about the areas being monitored: Information from this activity will be used to evaluate the plan's ongoing commitment to establish and maintain structures and processes that ensure the highest quality of care is delivered to MyCare enrollees. Information from this activity may also be used in the administrative compliance assessment as part of the State's efforts to reduce duplication with EQRO reviews.***

c. __X___ Consumer Self-Report data

__X_ Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS Survey

- ***Applicable programs: MCO***

- ***Personnel responsible: MCOs, CMS, EQRO, and State Medicaid***

- ***Detailed description of the activity:***

The MA & PDP CAHPS Survey assesses the experiences of enrollees in Medicare Advantage and Prescription Drug Plans, including Medicare-Medicaid Plans (MMPs). The survey includes 95 questions. The core survey questions consist of overall ratings and composite measures. Overall ratings are reported for 1) health plan, 2) health care, 3) drug plan, 4) personal doctor, and 5) specialist. Composite measures are reported for the following areas: 1) Getting Needed Care; 2) Getting Appointments and Care Quickly; 3) Doctors Who Communicate Well; 4) Care Coordination; 5) Customer Service; and 6) Getting Needed Prescription Drugs.

MyCare Ohio Plans are required to administer the MA &PDP CAHPS Survey and to send their survey data to CMS. Each plan contracts with a CMS-approved survey vendor for data collection and submission. Vendors follow CMS' MA & PDP Quality Assurance Protocols and Technical Specifications when collecting and submitting the data. CMS analyzes the data and prepares plan-specific reports of findings. CMS shares these reports with ODM. ODM obtains the plans' survey data (via a DUA) and associated reports from CMS and shares this information with the state's EQRO for analysis and reporting. The EQRO produces four reports for the state: a preliminary report with summary rates for core measures that's- produced shortly after receiving the data and used for internal management purposes, and three reports developed for a public audience - an executive summary report, full report with detailed findings, and a methodology report.
All EQRO reports contain plan-specific findings compared to the MyCare Ohio Program average.

- ***Frequency of use: The MA & PDP CAHPS Survey is administered on an annual basis. MyCare Ohio Plans first administered the survey in 2015.***

- ***How it yields information about the areas being monitored: The MA & PDP CAHPS Survey yields information regarding timely access to care, PCP/specialist care, coordination/continuity of care, and quality of care. Survey results provide important feedback that is used to improve enrollees' experiences with the plans and the program. The state will use the CAHPS results for ongoing monitoring and performance assessment. Contract standards are set for three measures through SFY 2019 (i.e., Annual Flu Vaccine, Getting Appointments and Care Quickly, and Satisfaction with Customer Service). Corrective action is imposed on plans for any noncompliance with these standards. The same CAHPS measures were used to determine quality withhold payments to the plans in DY1 or DY2. The EQRO reports are shared with the MyCare Ohio Plans for their use in evaluating their performance against the other MyCare Ohio plans and in allocating resources and targeting activities for QI initiatives.***

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__X_ Medicare Health Outcomes Survey (HOS)

- ***Applicable programs: MCO***

- ***Personnel responsible: MCOs, CMS, EQRO, and State Medicaid***

- ***Detailed description of the activity:***

  The Medicare Health Outcomes Survey (HOS) is a self-reported outcomes measure that primarily evaluates physical and mental health status. Additional health questions assess pain, depression, sleep quality, chronic conditions, and limitations on activities of daily living. The survey also includes four HEDIS measures that address management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women. The survey includes 68 questions. As a longitudinal instrument, change scores can be calculated for those individuals who complete both a baseline and follow up survey, allowing for the comparison of actual to expected changes. In this way, managed care plans can be evaluated on their ability to maintain or improve the health of their members over time.

  MyCare Ohio Plans are required to administer the HOS and to send their survey data to CMS. Each plan contracts with a CMS-approved survey vendor for data collection and submission. Vendors follow CMS' timelines and protocols when collecting and submitting the data. CMS analyzes the plans' data and prepares individual plan reports of findings. CMS shares these reports with ODM. ODM contracts with its EQRO to analyze each year's MyCare Ohio HOS data and prepare a report of findings for the state. The EQRO obtains the plans' data from CMS via a DUA. The EQRO's report contains individual plan results compared to the state average for all MyCare Ohio contracts. The report presents results for a different analytic population (i.e., members 18 years of age and older) than CMS' reports, which include members 65 years of age and older. In the EQRO's first (2016 Cohort 19 baseline) report

produced for the state, members under age 65 represent roughly half of the respondent population.

- ***Frequency of use: The HOS is administered in cohorts. Each cohort is surveyed twice: at baseline and two year follow-up.***

  The MyCare Ohio Plans administer two Health Outcome Surveys each year. The survey is administered to a new cohort to collect baseline data, while the cohort from two years prior is resurveyed to collect follow-up data. The 2016 Cohort 19 baseline survey was the first HOS administered by the MyCare Ohio Plans.

- ***How it yields information about the areas being monitored: The Medicare HOS is used to gather valid and reliable clinically meaningful data. Survey results provide important information regarding health plan performance in the area of quality of care. The HOS Fall Risk Management measure – Managing Fall Risk rate was used for contract compliance in ODM's Provider Agreement (PA) with the MyCare Ohio Plans from SFY 2016-SFY 2018. The measure is reporting only effective with the SFY 2019 PA. The state will continue to use the HOS results for ongoing monitoring, to track performance over time, identify opportunities for quality improvement, and to target QI activities and resources, The EQRO reports are shared with the MyCare Ohio Plans for their use in evaluating their performance against the other MyCare Ohio plans and in allocating resources and targeting activities for QI initiatives.***

__X_ State-developed survey

- ***Applicable programs: MCO***

- ***Personnel responsible: MCOs, EQRO and State Medicaid***

- ***Detailed description of the activity: The State will work with the EQRO to develop a survey instrument that will evaluate the enrollee's satisfaction with care management services and experience. The EQRO will administer the survey using a mixed mode approach of telephone and mail surveys in order to maximize the***

response rate. Questions in the following domains will be evaluated: Enrollee's participation in care management, satisfaction with care manager, involvement in developing the care plan; interaction/communication with the Plan; and satisfaction with care management services.

- ***Frequency of use: The survey will be completed in 2018 and every year thereafter, if possible.***

- ***How it yields information about the areas being monitored:***

  Survey results will yield information about coordination/continuity of services and quality of care. Results of the survey will be used by the State to refine the care management program and expectations that are specified in the Provider Agreement. Results of the survey and individual level data will be shared with the Plans to make improvements in their care management processes.

___ Disenrollment survey

_X__ Consumer/beneficiary focus groups (i.e., Beneficiary advisory committees)

- ***Applicable programs: MCO***

- ***Personnel responsible: MCOs and State Medicaid***

- ***Detailed description of the activity: MyCare Ohio Plans will be required to establish one beneficiary advisory committee per region and a process for that committee to provide input to the Plan's governing board. The MyCare Ohio plans must demonstrate that the advisory committee composition reflects the diversity of the ICDS enrollee population, and participation of individuals with disabilities, including enrollees, within the governance structure of the Plan.***

- ***Frequency of use: Quarterly***

- ***How it yields information about the areas being monitored: Information from this activity will help to***

provide information about information provided to beneficiaries, timely access, and grievances.

State staff will be invited to participate in the beneficiary advisory committee meetings. MyCare Ohio Plans will maintain documentation of items discussed at the beneficiary advisory committee and submit them upon request to the State. The state will review direct stakeholder input on both plan-specific and systematic performance. This feedback may be used to inform development of policy and to refine State processes for administration and oversight of the MyCare Ohio plans.

d. __X___ Data Analysis (non-claims)
___ Denials of referral requests
_X__ Disenrollment requests by enrollee
_X_ From plan

- ***Applicable program: MCO***
- ***Personnel responsible: State Medicaid and Managed Consumer Hotline***
- ***Detailed description of activity: Enrollees who wish to disenroll from a Plan call the Medicaid Consumer Hotline. Enrollees who wish to change MyCare Ohio plan can change plans at any time, effective the first of the following month. Enrollees can change MyCare Ohio plans for Medicaid only when they "opt-out" or elect to obtain their Medicare services outside the MyCare Ohio plan, only during the initial three months of membership, the annual open enrollment period, and when "Just Cause" is established. Members can also disenroll if they meet any of the exemption criteria as described in Part IV.C.***
- ***Frequency: Monthly***
- ***How it yields information about the areas being monitored: The State will use this information to monitor disenrollment and timely access.***
- ***Disenrollment requests will be tracked by the Medicaid Consumer Hotline and reported to the State. Corrective action will be requested as***

necessary to meet state access standards and program requirements.

__ From PCP within plan

__X_ Grievances and appeals data

- ***Applicable Program: MCO***
- ***Personnel Responsible: MCO and State Medicaid***
- ***Detailed Description of Activity: ICDS enrollees can contact their MyCare Ohio plans to file grievances to express their dissatisfaction with their MyCare Ohio plan or the MyCare Ohio plan's providers for a variety of reasons (e.g., access to care or dissatisfaction with providers). Enrollees file appeals to request review of MyCare Ohio plan's actions such as the denial, reduction, suspension or termination of services. The MyCare Ohio plan is required to resolve all grievances and appeals within specified timeframes.***

  MyCare Ohio Plans will be required to submit data to the State that document grievances and appeals received during the prior month in all regions for which the Plan has a provider agreement. Plans submit a monthly grievance file which includes a description and resolution for certain required grievance categories and a numeric count of other specified grievance categories. A monthly appeal file is also required to be submitted by the Plans.

- ***Frequency: Monthly***
- ***How it yields information about the area being monitored: Information from this activity will help to monitor the following areas: grievances, timely access and coverage/authorization. State staff will review monthly representative samples of grievances to verify accurate categorization, adequate resolution and to identify patterns State staff review and analyze monthly appeal reports***

to monitor timeliness and identify patterns and/or outliers related to resolution including effective 1/1/17 by service type. Audits may occur to evaluate appropriate identification and submission of grievances or in response to any observation in reported appeals or grievances to assure compliance with program requirements. Compliance action is taken by the State following the reviews of grievances or appeals if it is determined that the issues were not resolved or the MCO is in violation of a program requirement.

___ PCP termination rates and reasons

__X_ Other (please describe):

1) ***Care management data***

- ***Applicable program: MCO***
- ***Personnel responsible: MCO and State Medicaid***
- ***Detailed description of the activity: MyCare Ohio Plans are required to submit care management data for all enrollees including assignment to risk stratification, population stream and level of engagement. The State will specify the requirements for submission.***
- ***Frequency: Data will be submitted and reviewed no less than quarterly during the first full year of ICDS implementation. Data will be monitored on an as needed basis thereafter.***
- ***How it yields information about the area being monitored: Information will be used to monitor coordination/continuity of care requirements related to care management. Data may also be used as the basis for conducting comprehensive care management reviews and for reporting waiver assurance measures. Compliance actions will be taken if the State determines that the Plan is in violation of a program requirement.***

2) Waiver assurance measures and reporting

- ***Applicable program: MCO***

- ***Personnel responsible: MCO and State Medicaid***

- ***Detailed description of the activity: This waiver will operate concurrent with the 1915(c) waiver and is monitored consistent with the Quality Improvement Strategy described in both waivers. The MyCare Ohio plan will be required to report on performance measures and operational requirements as specified in the 1915 (c) waiver related to administrative authority, qualified providers, waiver service planning, and health and welfare.***

- ***Frequency: As specified in the 1915 (c) wavier.***

- ***How it yields information about the areas being monitored: This activity will yield information about timely access, coordination/continuity, coverage and authorization, provider selection and quality of care. The State will use data from MyCare Ohio plan reporting to assess and monitor Plan performance and to improve the delivery of care.***

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

- ***Applicable program: MCO***

- ***Personnel Responsible: State Medicaid, EQRO, and ODM's actuary***

- ***Detailed description: The State will use the EQRO and the actuary to conduct the independent assessment during the first two waiver periods. The State, actuary and the EQRO will work with CMS to ensure the methods employed by the independent evaluator are considered when conducting the independent assessment.***

- ***Frequency: Once per waiver period.***

- ***How it yields information about the area being monitored: The EQRO will use findings and results from many of the monitoring strategies outlined in this Section to evaluate the program impact, access, quality and cost effectiveness of the waiver.***

i. __X___ Measurement of any disparities by racial or ethnic groups

- ***Applicable program: MCO***

- ***Personnel Responsible: MCO and State Medicaid***
- ***Detailed description of activity: The State recognizes the reduction of health disparities as vital to improving health outcomes in the Medicaid population.***

  A structured, focused approach was needed to ensure success in this area. Efforts were therefore organized around improvement projects within each of ODM's five population streams: healthy women, chronic conditions, behavioral health, healthy children and healthy adults. Each improvement effort within these population streams therefore has an equity focus. To provide a driving force for these efforts, ODM has dedicated a full-time health equity position and has required each of its contracted managed care plans to commit to have MCOP health equity representatives actively involved in all improvement activities.

  In support of ODM's health equity efforts, MCOPs are required to collect and meaningfully use race, ethnicity and language data to identify and reduce disparities in health care access, services and outcomes. In addition to MCOP efforts, through its Hypertension Control Quality Improvement Project (QIP), ODM is exploring the feasibility of obtaining this information from clinical providers' electronic health records (EHRs).

- ***Frequency: MCOPs collect demographic data on their members as part of ongoing assessments, member outreach, and member surveys. Clinical data for the Hypertension QIP is collected every two weeks.***

- ***How it yields information about the area being monitored: Information from these efforts will help to monitor quality of care.***

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

- ***Applicable program: MCO***

- ***Personnel Responsible: MCO, State Medicaid and EQRO***

- ***Detailed description of activity: The assurance of adequate network access to health care services for MyCare enrollees is based primarily on Medicare's provider panel requirements. Specific regional network requirements for Long Term Care Services and Supports are specified in the 3-way agreement with CMS and the MyCare Ohio plan. Notwithstanding the minimum provider panel requirements, the MyCare Ohio plan must ensure access to all medically necessary Medicaid covered services for their enrollees. The State requires maintenance of a provider network that meets Medicare and Medicaid in all contracted regions to assure access for 1915(b) waiver consumers. The State monitors minimum provider panel requirements, including LTSS network requirements, via the Managed Care Provider Network (MCPN), a database that aggregates the number and type of providers in the MyCare Ohio plan's provider network and generates reports to indicate compliance with the State-specified minimum panel requirements outlined in the MyCare Ohio plan provider agreement. In addition, the state contracts with the EQRO will validate the accuracy of the data submitted to the MCPN. This validation occurs multiple times each year and includes both scheduled and targeted reviews.***

- ***Frequency: Quarterly***

- ***How it yields information about the area being monitored: Information from the quarterly reviews are used to monitor information to beneficiaries and provider selection. If reviews of the data identify that a Plan is non-compliant with minimum panel requirements, then the Plan is issued a notice of non-compliance and is assessed a fine. Continued non-compliance may result in a Plan being required to develop and implement a corrective plan of action.***

k. __X__ Ombudsman

- ***Applicable Program: MCO***
- ***Personnel Responsible: State Medicaid, Office of State Long-term Care Ombudsman Program***
- ***Detailed description of the activity: The Ohio Office of the State Long-Term care Ombudsman Program is statutorily authorized to advocate and investigate on behalf of Ohio's home and community based care and nursing facility-based recipients due to safeguard due process, and serve as the early and consistent means of identifying systematic problems. As MyCare is implemented, the Ombudsman activity and resources will expand from long term care facilities, as that is the current origin of most complaints, to a greater role for the Ombudsman in home and community based care. The Ombudsman will support individual advocacy and independent systematic oversight for MyCare, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community based care context. The Ombudsman will be responsible for gathering and reporting data to the State and CMS via the contract management team.***
- ***Frequency of use: No less than quarterly.***
- ***How the activity yields information about the area being monitored: Feedback provided by the***

Ombudsman will provide information about choice, marketing practices, information to beneficiaries, timely access, coordination/continuity, and quality of care. The state will review Ombudsman feedback on both plan-specific and systematic performance. This feedback may be used to inform development of policy and to refine State processes for administration and oversight of the MyCare Ohio plans.

l. __ X___ On-site review

- ***Applicable Programs: MCO***

- ***Personnel responsible: MCOs, State Medicaid and EQRO***

- ***Detailed description of the activity: On-site reviews will be used to evaluate Plan compliance with state and federal managed care regulations and to monitor compliance with waiver assurances. The on-site reviews will consist of reviews of policies and procedures, file reviews, and interviews with Plan staff.***

  Categories of topics that will be evaluated by the State or EQRO are as follows: availability of services, assurance of adequate services and capacity, coordination and continuity of care, coverage and authorization of services, credentialing and re-credentialing, subcontracting and delegation, enrollee rights and information, grievance process, quality assessment and performance improvement programs, health information systems and program integrity.

  Because this waiver also operates concurrent with the 1915(c) waiver and is monitored consistent with the Quality Improvement Strategy described in both waivers and SPA, the EQRO will be used to conduct site visits to monitor compliance with waiver assurances. The EQRO will collect data relative to administrative authority, waiver service planning, and health and welfare.

- ***Frequency of use: On-site reviews will be conducted more frequently (i.e., quarterly) during the first year of***

MyCare implementation and may decrease to semi-annually or annually especially if routine monitoring of an MyCare Ohio Plan's performance yields continuous satisfactory results.

- ***How it yields information about the areas being monitored. On-site reviews will yield information about the following areas: marketing, program integrity, grievances, timely access, PCP/specialist capacity, coordination/continuity, coverage/authorization, provider selection and quality of care.***

  Information from the reviews will be used to: 1) determine compliance with state and federal regulations; 2) evaluate the quality and timeliness of, and access to, care and services furnished to enrollees; and 3) identify interventions to improve quality, timeliness, and accessibility of services. Upon completion of the reviews by either the State or the EQRO, if areas of noncompliance are subject to sanctions including but not limited to corrective action plans, fines and potential termination.

m. _X___ Performance Improvement projects [Required for MCO/PIHP]
_X__ Clinical
_X__ Non-clinical

- ***Applicable program: MCO***

- ***Personnel responsible: State Medicaid, MCO and EQRO***

- ***Detailed description of activity:***

  The State expects performance improvement projects (PIPs) to be multi-year structured quality improvement projects that are designed to achieve, through use of the Model for Improvement and rapid cycle testing to determine intervention effectiveness, a favorable impact on health outcomes and experience of care for MyCare enrollees. MyCare Ohio plans will be expected to develop and implement one chronic condition improvement project and one quality improvement project in topics selected by ODM.

For each improvement project, the State selects the study topics which reflect burgeoning issues or high priority clinical issues for the MyCare population. Priority is given to projects that help to reduce health disparities. The State involves the EQRO in monthly QI calls related to the study topic, selected indicators, and progress towards the goal. The Plans are responsible for establishing baseline measurements, benchmarks (aims), and developing and assessing improvement strategies that impact results. Plans will report progress in accordance with the CMS PIP Protocols.

In October of 2017, ODM received permission to transition MyCare Ohio improvement projects from a pre-post test model to a rapid cycle intervention process based on the Model for Improvement. The granting of permission aligned with the end of the rebalancing QIP and allowed ODM to align Medicaid and MyCare efforts to address population health concerns with the new QIP aimed at addressing racial disparities in hypertension control.

Within the collaborative framework of the Hypertension QIP, Ohio's MyCare Plans are working with Ohio's Medicaid Plans to spread best clinical practices and remove administrative barriers as part a statewide learning collaborative consisting of 10 clinical sites, Case Western Reserve University and the Ohio Colleges of Medicine Government Resource Center (GRC).

The project uses EHR data from participating clinical sites to assess progress in controlling blood pressure and reducing racial disparities. Plans submit project progress in the form of modules developed by the EQRO which correspond to each phase of the project (initiation, SMART Aim Data Collection, Intervention Determination, Plan-Do-Study-Act [Intervention testing], and Conclusions). Validation of the improvement projects is in accordance with Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.

- ***Frequency: Results are reported annually to the Stat****e.*
- ***How it yields information about the areas being monitored:***

Information from this activity will be used to monitor MCP efforts to improve timely access, coordination/continuity and quality of care.

The EQRO's Rapid Cycle Performance Improvement Project (PIP) validation methodology is used to determine whether an improvement project is valid and to rate the percentage of compliance with the CMS protocol for conducting PIPs. In addition, ODM's Quality Improvement Project staff use module submissions and monthly QI calls with each MyCare Ohio plan to facilitate learning and accelerate improvement. Each improvement project consists of elements that are critical to the successful completion of the improvement project. Elements are assigned a rating by the EQRO of Met, Partially Met, Not Met, Not Assessed, and Not Applicable. The ratings translate to an overall percentage score and an indication of whether the EQRO is confident in the results of the improvement project being valid and reliable. Improvement projects have variable timelines. Quality improvement projects were established by CMS to be terminated at the conclusion of three-years. Chronic Condition Improvement Projects were established by CMS to be terminated after five years. Once the current Chronic Condition Improvement Project reaches the five year termination mark, ODM plans to also transition these improvement projects to using the rapid cycle intervention testing inherent to the Model for Improvement.

n. __X___ Performance measures [Required for MCO/PIHP]

__x_ Process

__X_ Health status/outcomes **The information for this measure is found in B.II.(c) above.**

__X_ Access/availability of care

__X_ Use of services/utilization

__X__Health plan/provider characteristics

__X_ Beneficiary characteristics

- ***Applicable programs: MCO***
- ***Personnel responsible: MCO, CMS, and State Medicaid***

- ***Detailed description of the activity: MyCare Ohio plans will be required to report on all measures listed in the following table. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements. Any additional Medicaid measures identified by the State and all existing Part D metrics will be collected as well. MyCare Ohio plans must submit data consistent with requirements established by CMS and/or the State. MyCare Ohio plans will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D. The State will supplement quality reporting requirements with additional state-specified measures.***

  CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing Plan performance and outcomes, and to allow quality to be evaluated and compared with other Plans in MyCare. A subset of these measures (denoted as State Specific in the Measure Set column) will also be used for calculating the quality withhold payment and for determining monetary sanctions tied to premium payments that will be applied for not meeting minimum performance standards. The subset consists of a combination of national and State-specific metrics appropriate for the MyCare population, including measures for acute care, nursing facility care and rebalancing and diversion from nursing facilities.

- ***Frequency of use: Annually for performance monitoring but some measures may be calculated more frequently for trending and quality improvement initiatives.***

- ***How it yields information about the areas being monitored****:*

  Performance measures provide information related to timely access, coordination/continuity and quality of care.

MyCare Ohio Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. The State-specified measures (denoted by the Xs in the attached table) will be used for monitoring as described above, and were selected specifically for Ohio's MyCare population based on data driven analyses. The clinical focus areas associated with the performance metrics were identified as prevalent for the ICDS population.

A subset of measures were selected to monitor integration of services and care coordination. In addition, one of the key goals of Ohio's MyCare Program is to ensure consumers are receiving care in the appropriate setting, with an emphasis on nursing facility diversion and rebalancing.

Several of the State-specified measures will be used as quality withholds to incentivize diversion and rebalancing. Results of all of the quality measures will be used by the State to trend results over time, identify best practices, target areas of deficiencies and opportunities for improvement, and refine performance expectations. Results of the measures will be shared with the ICDS Plans to drive improvements in their quality initiatives for the MyCare population.

	MyCare Quality Measures	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year
Behavioral Health	Follow-up After Hospitalization for Mental Illness -30 Day Follow Up	NCQA/ HEDIS	≥ 41.2%	CY 2016
	Anti-depressant Medication Management	NCQA/ HEDIS	Effective Acute Phase Treatment ≥62.8%	CY 2016
			Effective Continuation Phase Treatment: ≥47.4%	
Chronic Conditions	Controlling High Blood Pressure X	NCQA/ HEDIS	≥ 47.0%	CY 2016
	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/ HEDIS	≥ 58.3%	CY 2016
	Part D Medication Adherence for Diabetes Medications X	CMS	≥ 69.0%	CY 2016
Healthy Adults	Annual Flu Vaccine	CAHPS	≥ 63.0%	CY 2016 (Survey conducted in CY 2017)
	Fall Risk Management – Managing Fall Risk	NCQA/ HEDIS/ HOS	≥ 53.0%	CY 2016 (Survey conducted in CY 2017)

	Breast Cancer Screening	NCQA/ HEDIS	≥ 66.0%	CY 2016
Integrating Care	Plan All Cause Readmissions – Observed Readmissions (Num/Den)	CMS	≤. 11.0%	CY 2016
	Adults' Access to Preventive/Ambulatory Health Services	NCQA/ HEDIS	≥ 94.0%	CY 2016
	Getting Appointments and Care Quickly Composite	CAHPS	≥ 74.0%	CY 2016 (Survey conducted in CY 2017)
	Satisfaction with Customer Service Composite	CAHPS	≥ 85.0%	CY 2016 (Survey conducted In CY 2017)
	Care for Older Adults - Medication Review, 66 & Older	NCQA/ HEDIS	≥ 60.0%	CY 2016
	Care for Older Adults – Functional Status Assessment, 66 & Older	NCQA/ HEDIS	≥ 54.0%	CY 2016
	Care for Older Adults – Pain Assessment, 66 & Older	NCQA/ HEDIS	≥ 62.0%	CY 2016
Rebalancing Long Term Care	Nursing Facility Diversion Measure X	Ohio-Specific	n/a	CY 2016
	Long Term Care Rebalancing Measure X	Ohio-Specific	n/a	
	Long Term Care Overall Balance Measure X	Ohio Specific	n/a	
Improving Long Term Care / Nursing Facility Measures	Percent of residents whose need for help with daily activities has increased	MDS / RTI International	≤ 17.6%	CY 2016
	Percent of residents who were physically restrained		≤ 2.1%	
	Percent of residents experiencing on or more falls with a major injury		≤ 3.6%	
	Percent of residents with urinary tract infection		≤ 5.8%	
	Percent of high-risk residents with pressure ulcers		≤ 5.6%	
	Percent of residents who have/had a catheter inserted and left in their bladder		≤ 3.0%	

__X_Health plan stability/financial/cost of care

- ***Applicable programs: MCO***
- ***Personnel responsible: MCO, State Medicaid, the contracted actuary***
- ***Detailed description of the activity: The State will use several different reports and data sources, such as the National Association of Insurance Commissioners' (NAIC) financial statements and quarterly and annual state-designated cost reports, to monitor the financial status of Plans and cost of care. The State will use quarterly and annual cost reports to monitor the Plans' actual costs of providing care. The NAIC financial statements will be used to monitor Plans' revenue and expenses to evaluate financial status. The annual cost report will be used to monitor Plan compliance with financial performance standards established in the contract, such as, administrative expense ratio, minimum medical loss ratio and overall expense ratio.***

- ***Frequency of use: The State requires submission of the quarterly and annual cost reports.***

- ***How it yields information about the areas being monitored: Data from these reports will be used to monitor compliance with financial performance measures. If a Plan does not meet one or more of the financial performance measures, the Plan will be subject to compliance actions such as a corrective action plan or monetary penalties. The annual NAIC financial statement, quarterly and annual cost reports, as well as encounter data will be shared with the State's contracted actuary for use in setting the Medicaid portion of the capitation rates.***

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

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

q. __X__ Provider Self-report data

_X__ Survey of providers (Ohio Medicaid Managed Care Provider Satisfaction Survey (Primary Care Providers))

___ Focus groups

- ***Applicable programs: MCO***

- ***Personnel responsible: State Medicaid, EQRO***

- ***Detailed description of the activity: In CY 2018, ODM implemented the use of a Provider Satisfaction Survey of primary care providers contracted with one or more of the state's Medicaid and/or MyCare Ohio managed care plans. The survey sampling, data aggregation, and reporting are not program-specific. Data collection, analysis, and reporting are performed under contract by the state's EQRO vendor. The survey instrument used for 2018 is a customized tool developed by the state's EQRO in collaboration with ODM. It contains 16 questions that capture 10 indicators (i.e., measures). The remaining questions gather demographic data. One report of findings is produced by the EQRO. The report presents results at the plan and program levels. This survey will be conducted annually. Additional or***

different populations of providers (e.g., specialists, behavioral health) may be surveyed in future years.

- ***Frequency of use: The State will administer this survey on an annual basis. Data collection, analysis, and reporting activities will be contracted to its EQRO. The first provider satisfaction survey was conducted in 2018.***

- ***How it yields information about the areas being monitored: Data from the state's Provider Satisfaction Survey yields information regarding PCP/Specialist capacity, coverage/authorization, and quality of care. The state is using the information derived from the 2018 survey to assess plan performance and identify activities for quality improvement. Future surveys will be used for ongoing monitoring, to trend results over time, and to identify potential opportunities for quality improvement.***

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 MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

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

_X__ This is a renewal request.

- _X__ 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)

STRATEGY

a). Strategy: **Accreditation for Non-duplication**
Confirmation it was conducted as described:

__x_ Yes
___ No. Please explain:
Summary of results: Ohio's EQRO, Health Services Advisory Group, completed a review of the 2016 NCQA and Version 7.3 URAC health plan standards to identify areas of overlap with the deem-able Medicaid CFRs. Out of 58 deemable Medicaid CFRs, there were 20 NCQA, 24 URAC, and 19 Medicare standards that were 100% comparable with the Medicaid CFRs. MCOPs that received full compliance with the applicable accreditation element were exempted from a review of the equivalent CFR. ODM disallowed deeming for any MCP if there were any-MCP specific performance related issues and/or any remedial actions taken or sanctions assessed since the last comprehensive administrative review.

Problems identified: None

Corrective action (plan/provider level): N/A

Program change (system-wide level): N/A

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

_*X*_ *NCQA*
___ *JCAHO*
___ *AAAHC*
_____*Other (please describe)*

Confirmation it was conducted as described:

_x__ Yes
___ No. Please explain:
Summary of results: MCOPs submit their accreditation from NCQA on an annual basis. The results are posted to the ODM website http://medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures.

Problems identified: None

Corrective action (plan/provider level): N/A

Program change (system-wide level): N/A

c). Strategy: Consumer Self-Report data

__X_ *CAHPS (Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS Survey)*

Confirmation it was conducted as described:
X___ Yes
___ No. Please explain:

Summary of results:

Molina and UnitedHealthcare did not meet the SFY 2016 (CY 2015) contract standard (≥69.0%) set for the Annual Flu Vaccine measure in ODM's Provider Agreement with the plan. Molina's result for this measure was 61.7% while UnitedHealthcare's result was 65.2%.

Buckeye Health Plan did not meet the DY1 CY 2015 Quality Withhold benchmark of 86.0% for the Customer Service measure. The plan's result for this measure was 83.0%. As a result, the plan was awarded 75% of their total revenue withheld for the DY1 CY 2015 Medicaid Quality Withhold determination. Had the plan met the benchmark, they would have been awarded 100% of their withheld amount.

All other plan results met all other contract standards and Quality Withhold benchmarks for all other years covered under the original waiver.
Problems identified: No systemic issues were identified through review of these results.

Corrective action (plan/provider level): N/A

Program change (system-wide level): No program changes were made following review of these results.

__X_ Medicare Health Outcomes Survey (HOS)
Confirmation it was conducted as described:
___ Yes
_X__ No. Please explain: This activity was not described in the previous waiver submission because CMS did not require the MyCare Ohio Plans to conduct the Medicare HOS until 2016. The first HOS administered by the plans was the 2016 Cohort 19 baseline survey.

Summary of results: The HOS results calculated by the state's EQRO vendor are calculated using a different analytic population (i.e., members 18 years of age and older) than CMS' reports, which include members 65 years of age and older. In the EQRO's first (2016 Cohort 19 baseline) report produced for the state, members under age 65

represent roughly half of the respondent population. Following are the summary findings from this report.

Respondents had relatively low PCS and MCS scores (30.1 and 43.4 for the program, respectively, on a scale of 0 to 100 where higher scores indicate better health status). Furthermore, respondents reported, on average, being unhealthy less than half of the days in a month: 14 physically unhealthy days, 11 mentally unhealthy days, and 11 days with activity limitations. The PCS and MCS scores were lower when indicating poor health, which is expected. For example, lower PCS and MCS scores were associated with respondents reporting more unhealthy days, those with depression and higher pain scores, those with a reported impairment on an ADL or IADL, and those with less sleep. The prevalence of no IADL impairments was fairly high with 60 percent of respondents reporting no impairments in performing IADLs; however, the prevalence of no ADL impairments was lower with approximately 30 percent of respondents reporting no impairments in performing ADLs. This finding indicates that the majority of respondents had at least one ADL impairment, while a smaller number of respondents had at least one IADL impairment. The MyCare Ohio Program's results for the Effectiveness of Care NCQA HEDIS measures exceeded the 2016 NCQA National Average for six out of eight measures. These are the only measures for which a national average was available for comparison in the EQRO's report. All plans met ODM's SFY 2016 contract standard set for the Fall Risk Management measure – Managing Fall Risk rate.

Problems identified: No systemic issues were identified through this review of baseline survey results.

Corrective action (plan/provider level): No corrective actions were taken as a result of this review.

Program change (system-wide level): No program changes were made as a result of this review.

__*X*__ *State-developed survey*

Confirmation it was conducted as described:
___ Yes X
___ No. Please explain:

- Summary of results: The State conducted a care management survey to evaluate MyCare Ohio Plans enrollees' experiences with their care management program, including their satisfaction with the services received. Results were mostly favorable. The MyCare Ohio plans scored positively, approximately 70%, in satisfaction with the care manager. All MyCare Ohio Plans scored approximately 90% when evaluating the relationship with the care manager. This indicates that the enrollee felt the care manager explained things in a way that could be understood, treated enrollees with respect, and listened carefully.

Problems identified: Opportunity for improvement included better communication of member information between care managers during transitions.

Corrective action (plan/provider level): No corrective actions were taken as a result of these specific findings.

Program change (system-wide level): The MyCare Ohio Plans were provided the results of the survey to make improvements in care management processes.

_X__ Consumer/beneficiary focus groups (i.e., Beneficiary advisory committees)

Confirmation it was conducted as described:
_X__Yes
___No. Please explain:
Summary of results: The monitoring of beneficiary advisory committees has occurred as the state described it would. State staff have attended (without prior notification to the plans ahead of time) a sample of these meetings since the launch of MyCare Ohio to ensure the meetings are occurring, plans have recruited a diverse member population and that plans are responsive to members' concerns and recommendations. Additionally, each plan is required, on a quarterly basis, to submit to the state minutes from the quarterly beneficiary advisory committees. The state reviews the meetings to ensure the plans are meeting the related requirements.
Problems identified: Through our monitoring, the state was made aware of transportation challenges members were experiencing, including late and missed pick-up times. This led to ODM amending our contract with the plans to state clearer expectations regarding pick-up and drop times.
Corrective action (plan/provider level): N/A
Program change (system-wide level): The state is also aware that the plans have used the feedback received from these meetings to improve their member marketing materials, as well as to add new value-added benefits members have requested.

d**).** ***Data Analysis (non-claims)***

___ *Denials of referral requests*
_X__ *Disenrollment requests by enrollee*
_X_ From plan
_X_ Grievances and appeals data
_____PCP termination rates and reasons
__ *X_ Other (please describe): Care management data*

Disenrollment Request by Enrollee

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of results: Individuals contacted the enrollment hotline to request disenrollment. Disenrollments were processed and effective the end of the month the request was made.
Problems identified: None
Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

Grievances and appeals data

Confirmation it was conducted as described:
_x__ Yes
___ No. Please explain:
Summary of results: Appeals -the plans demonstrated improvement each year of the demonstration for the percent of standard appeals that were resolved timely. Demonstration year 3 there were 1,697 standard appeals and 99% were resolved timely. For expedited appeals, plans remained consistent on the percent resolved timely throughout the demonstration at 95%. Because the number of expedited appeals is low, the percent can be significantly impacted by one or two records. Whether or not a plan requires prior authorization for service types that subsequently can be appealed can impact percentages when monitoring for patterns or outliers. The number of appeals for service denials sustained (plan changed their initial decision) averaged around 33% for the first 2 years of the demonstration. In the 3rd year one plan was an outlier for % sustained and number of appeals which caused the percent sustained to rise to 59%. Excluding that one plan's results, other plans' results stayed at 33%. A review of the one plan's processes did not identify any issues. We are just beginning to analyze data to determine if there are any patterns or outliers by service type.
Problems identified: Data reporting issues related to clarity around service type and whether all Medicare primary payer services were being reported were identified. A technical assistance session was conducted in December 2016 as well as plan specific calls to address the issues.

Corrective action (plan/provider level): Monitoring results did not necessitate corrective action by any plan
Program change (system-wide level):

Other: Care management data

Confirmation it was conducted as described:
___ Yes
_X__ No. Please explain:

Summary of results: Due to changes implemented in the MyCare Ohio program in October 2017, ODM updated care management data submission requirements. Submission of the new data files occurred in July 2018.
Problems identified: N/A
Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

Other: Waiver assurance measures and reporting

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of results: ODM submits annual 372 reports to CMS in accordance with 1915(c) guidelines.
Problems identified: N/A
Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

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, quality, and cost-effectiveness (Required for first two waiver periods)**

Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain:
Summary of results: ODM demonstrated robust expectations, monitoring, and oversight for all areas reviewed by HSAG in this independent assessment, showing overall consistency in all HSAG-assessed areas related to Ohio's ICDS Waiver. ODM's processes and MCOP performance are well-aligned with the commitments made in the ICDS Waiver application. These processes also demonstrate enhancements in comparison to existing Medicaid fee-for-service (FFS) processes, thereby showing the ICDS Waiver assures member access to

services and quality of care are comparable or improved in comparison to pre-Waiver enrollment. While minor program improvement recommendations are noted in this report, no areas of risk or concern were identified, as both access to care and quality of care have been determined to be as effective or more effective than the access to and quality of care received prior to the ICDS Waiver. Milliman compared actual waiver expenditures to initial projections to assess the waiver's cost-effectiveness and found that the waiver program appeared to be cost-effective according to CMS established standards. HSAG and Milliman identified no required areas of correction that would prevent ODM from continuing the current ICDS Waiver program.

Problems identified:
Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

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

Confirmation it was conducted as described:
___ Yes
_x__ No. Please explain:
Summary of results: Summary of results: The Health Equity Workgroup was restructured to be focused on specific improvements to areas in which disparities had been identified (e.g., preterm birth, hypertension control, etc.). This restructuring, along with the assignment of a full-time ODM health equity lead and the requirement that MCPs have health equity representation as a part of all improvement projects has increased the focus on health equity and allowed plans to work together on a common, prioritized goal and associated outcome and process measures.

Due to the inability to require ethnicity and race information when applicants apply for Medicaid, ODM and its MCPs must explore creative ways of gathering this information in order to determine the extent of ethnic and racial disparity and the success of efforts to reduce these gaps. To that end, he current prioritized improvement project focuses on reducing disparities in hypertension control. The ten participating clinical practices receive training in standardized methods for obtaining ethnicity and race information based on how patients self-identify. This information is entered into the EHR. Information from the EHR is uploaded to the GRC portal on a biweekly basis, allowing the MCPs to have a more accurate and complete picture of how effective their interventions are in reducing disparities in hypertension control.
Problems identified: Payer information from electronic health records is not as readily identified as was initially anticipated. This has resulted in difficulties in determining which patients belong to which MCP and whether the patient is part of the Medicaid or MyCare population.
Corrective action (plan/provider level): Through GRC, ODM will be contracting with consultants with expertise in EHRs to determine how best to tease out this information. The MCPs are also providing lists of their patients to GRC in order to cross reference this information with what is in the portal. Additionally, MCPs are exploring the use of

algorithms incorporating personally identifiable information to better extract their unique members from the EHR data.
Program change (system-wide level): N/A

Problems identified:
Corrective action (plan/provider level):
Program change (system-wide level):

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

Confirmation it was conducted as described:
___ Yes
__X_ No. Please explain: The ODM monitoring strategy was implemented as planned. ODM revised the monitoring strategy completed by the EQRO. In SFY 2015 and SFY 2016, the EQRO conducted quarterly, regional secret-shopper surveys to assess PCP provider networks. For the MyCare program, the EQRO evaluated provider network reporting accuracy by assessing the accuracy of PCP availability (e.g. PCP Accepting new Patients) and timely access to PCP services (e.g. Average Wait Time in Days for Appt). Through this review process, ODM discovered a lack of data on appointment times. Because surveys were conducted without disclosure, the number of PCPs from whom appointment availability was obtained became limited. The secret-shopper strategy precluded callers from leaving messages when a practice could not be reached for a live answer, further limiting overall practice participation beyond the ones that were not able to be contacted. In addition, once providers were reached, if they reported not accepting new patients, no further questions were asked. The secret-shopper strategy resulted in skewed availability results because providers were filtered out of the survey based on responses.

Due to the restrictions inherent with a secret-shopper survey approach, beginning in quarter 2 of SFY 2017, ODM began developing an alternative PCP services review strategy. PCP services were evaluated using a revealed caller survey rather than a secret-shopper approach. Using this new method, additional details are available from the providers. In addition, the sampling strategy has been revised. Oversampling is also now being used to account for the providers who are unable to be reached (i.e. due to inaccurate contact information or failure to return calls). Other revisions to the review strategy include PCP surveys being conducted semiannually and the sampling is statewide rather than by region. The revised strategy was piloted in Q4 of SFY 2017. The initial implementation of this review strategy excluded MyCare because of the PCP Medicare coverage.

In addition, to these noted changes, ODM also developed and the EQRO implemented surveys of specialty provider availability. Initial surveys were conducted in SFY 2018,

beginning with OB/GYN practitioners and home health agencies. The surveys are being conducted for both MyCare and Medicaid Managed Care (MMC) since many providers render care in both programs.

Summary of results: For the review period, a total of $47,000 in fines for non-compliance were collected from the five MyCare plans across all provider panel requirements. While each plan was found non-compliant at least once during the review period, no plan had non-compliance each quarter. With corrective measures taken, all plans met the panel requirements in the quarter consecutive to the non-compliance being issued. All plans met the panel requirements for MyCare in each quarter of SFY 2017 and the first two quarters of SFY 2018.

MCOP	Date of Noncompliance Notice	Total Fine Assessed	Due Date of Fine	Reason/Comments
Aetna MyCare				
Aetna	08/18/15	$13,000.00	9/18/2015 **Revised due date 11-10-2015**	**Request for Reconsideration approved in part. Revised amount 13,000.00.** Failure to meet the provider panel requirements in the region(s) for which Aetna holds a provider agreement.
Aetna	11/06/15	$1,000.00	12/6/2015	Failure to meet the provider panel requirements in the region(s) for which Aetna holds a provider agreement.
Aetna	08/03/17	$2,000.00		Failure to meet the provider panel requirements in the region(s) for which Aetna holds a provider agreement
Buckeye MyCare				

MCOP	Date of Noncompliance Notice	Total Fine Assessed	Due Date of Fine	Reason/Comments
MyCare-Buckeye	08/13/15	$2,000.00	9/13/2015	Failure to meet the provider panel requirements in the regions(s) for which Buckeye holds a MyCare provider agreement.
MyCare-Buckeye	10/27/15	$2,000.00	11/27/2015 **revised due date 1-11-2016**	**Request for Reconsideration denied.** Failure to meet the provider panel requirements in the region(s) for which Buckeye holds a provider agreement.
MyCare-Buckeye	01/12/16	$1,000.00	2/9/2016	Failure to meet the provider panel requirements in the region(s) for which Buckeye holds a provider agreement.
MyCare-Buckeye	05/02/18	$4,000.00		Failure to meet the provider panel requirements in the region(s) for which Buckeye holds a provider agreement
CareSource MyCare				
MyCare-CareSource	08/12/15	$8,000.00	9/10/2015	**Request for Reconsideration denied**. Failure to meet the provider panel requirements in the region(s) for which CareSource holds a provider agreement. Provider Panel Compliance.

MCOP	Date of Noncompliance Notice	Total Fine Assessed	Due Date of Fine	Reason/Comments
MyCare-CareSource	10/23/15	$4,000.00	11/23/2015	Failure to meet the provider panel requirements in the region (s) for which CareSource holds a provider agreement
MyCare-CareSource	01/15/16	$4,000.00	2/15/2016 **revised due date 3/26/2016**	**Request for Reconsideration denied** Failure to meet the provider panel requirements in the regions(s) for which CareSource holds a provider agreement.
MyCare-CareSource	5/2/18	$1,000.00		April 2018 Provider Panel Deficiencies
Molina MyCare				
MyCare-Molina	01/12/16	$1,000.00	2/8/2016 **revised due date 3-7-2016**	**Request for Reconsideration denied**. Failure to meet the provider panel requirements in the region(s) for which Molina holds a provider agreement.
UnitedHealthcare MyCare				
UnitedHealthcare	11/05/15	$1,000.00	12/5/2015	Failure to meet the provider panel requirements in the region(s) for which UnitedHealthcare (UHC) holds a provider agreement
UnitedHealthcare	01/15/16	$1,000.00	2/16/2016	Failure to meet the provider panel requirements in the region(s) for which UnitedHealthcare

MCOP	Date of Noncompliance Notice	Total Fine Assessed	Due Date of Fine	Reason/Comments
				holds a provider agreement
UnitedHealthcare	08/09/17	$2,000.00	8/23/2017	Failure to meet the provider panel requirements in the region(s) for which UnitedHealthcare holds a provider agreement
UnitedHealthcare	5/15/2018	$1,000.00	5/29/2018	Failure to meet the provider panel requirements in the region(s) for which UnitedHealthcare holds a provider agreement

The PCP services survey demonstrated variance on availability across regions. Across the MyCare plans, the wait time for a PCP appointment for new patients ranged from 20-40 days. The rate of new patient acceptance was also found to be highly variable by region. However, these rates are not generalizable because of the limited response rate due to the review strategy deployed. The revised PCP review strategy is expected to have reliable data.

PCPs Accepting New Patients - MyCare* (%)

	SFY2015				SFY2016				SFY2017				SFY2018
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Aetna	**	**	*	52	51.2	*	45.7	30	*	**	**	~	^
Buckeye	**	**	81.1	*	34.8	70.7	*	40.6	76.3	**	**	~	^
CareSource	**	**	73.3	*	*	74.8	*	*	76	**	**	~	^
Molina	**	**	*	43.2	31.4	*	31.6	38.6	*	**	**	~	^
United	**	**	61.8	*	*	80.4	*	*	79.3	**	**	~	^
Overall Average	**	**	71.6	47.6	40.6	74.2	38.4	36.8	76.6	**	**	~	^

PCPs Average Wait Time In Days for an Appt (New Patients) - MyCare*

SFY2015	SFY2016	SFY2017	SFY2018

	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Aetna	**	**	*	54.2	33.6	*	34.7	37	*	**	**	~	^
Buckeye	**	**	17.2	*	38.5	22.3	*	28.1	27.3	**	**	~	^
CareSource	**	**	22.5	*	*	26.8	*	*	21.5	**	**	~	^
Molina	**	**	*	25.4	34.2	*	16.4	26.2	*	**	**	~	^
United	**	**	12.4	*	*	21.1	*	*	16.9	**	**	~	^
Overall Average	**	**	19.1	39.8	35.4	24.1	23.5	29.8	23.3	**	**	~	^

**Survey development
~Pilot for new survey strategy.

*Plan not available in the region surveyed.
^MyCare not included in survey.

The OB/GYN survey revealed that, in general, new patients are able to be seen within 20 days during the first trimester and within 16 days during the second trimester, across the plans. On average, 10% of the practices were not accepting new patients. The home health agency survey revealed that 85% of the agencies offer ongoing nursing services, while nearly 90% offer ongoing aide services and 70% offer services to all ages. In general, providers identified accepting both the plan (99%) and the program (>85%), verifying accuracy in the plan's reported network availability. One area for further evaluation is access to care in rural areas, where over 50% of the providers reported some potential staff timing differences.

	SFY2018		
	Q2		Q3
Specialists Reviews	OB/GYN Average Wait Time in Days for an Appt (New Patients 1st Trimester)		Home Health Agency Reported Program Participation (%)
Aetna	15.6		86.1
Buckeye	19.1*		96.4*
CareSource	16.7*		88.3*
Molina	16.3*		94.8*
United	16.5*		90.6*
*Includes MyCare and MMC			

Problems identified: There were no systemic issues identified through the ODM monitoring process. As is noted above, variations noted in the EQRO monitoring process

for PCP survey resulted in a need to revisit the survey strategy. The revised implementation has yet to be implemented in MyCare.

Corrective action (plan/provider level): When a plan failed to meet panel requirements in specified areas, a notice of non-compliance was issued and fines were assessed. In addition, Plans are provided their survey-specific results at the end of each EQRO review cycle.

Program change (system-wide level): No program changes were made as a result of this review process.

k). **Ombudsman**

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of results: the ombudsman office operates out of the Department of Aging and continues to be a resource for MyCare recipients to provide support/guidance. Reports are submitted and reviewed with the state and CMS quarterly.

Problems identified: N/A
Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

l). **On-site review**

Comprehensive Administrative Review:
Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain:
Summary of results: In Spring 2017, the EQRO conducted on-site reviews to determine the extent to which the MCOPs met federal and state program requirements. These requirements were organized into 13 standards that included the following: availability of services, assurance of adequate capacity and services, coordination and continuity of care, coverage and authorization of services, credentialing and re-credentialing, sub-contractual relationships and delegation, member information and member rights, confidentiality of health information, enrollment and disenrollment, grievance system, practice guidelines, quality assessment and performance improvement, and health information systems. The EQRO calculated a performance score for each standard and an overall score across the 13 standards. All MCOPs had an overall score (across all 13 standards) of 90% or higher on the administrative review.

Problems identified: Opportunities for improvement were identified in the following standards: assurance and adequate capacity and services, coverage and authorization of services, credentialing and recredentialing, member information and member rights, confidentiality of health information, practice guidelines, grievance system, and QAPI.
Corrective action (plan/provider level): An MCOP was required to develop and implement a corrective action plan for any element that received a not met rating.
Program change (system-wide level): N/A

Care Management Reviews
Confirmation it was conducted as described:
___ Yes X
___ No. Please explain:

- Summary of results: On-site reviews are completed by the EQRO quarterly to evaluate MyCare Ohio Plans' care management programs. Because this waiver also operates concurrent with the 1915(c) waiver, the EQRO also monitors compliance with waiver assurances. The reviews consist of file reviews and interviews with Plan staff. The following domains are reviewed: Assessment, Individualized Care Plan, Waiver Service Provision, Care Manager/Care Management Team, Beneficiary Interaction and Health and Welfare. Results of the reviews are used to identify strengths and areas needing attention and to report federal waiver assurances. The MyCare Ohio Plans have scored favorably in timely completion of initial assessments, person-centered care plans including priorities, goals, interventions and outcomes, waiver services delivered in accordance with the waiver service plan, and the care manager contacting the enrollee according to the agreed-upon contact schedule.
  Problems identified: Areas for opportunity include assuring effective transitions of care between settings (e.g. admissions or discharges from nursing facility or hospital to the community), identifying and rectifying gaps in care, engaging care team in care planning process and partnering with facilities to assure safe and appropriate discharge place by conducting timely follow up and arranging for adequate services and supports.
  Corrective action (plan/provider level): Each MyCare Ohio Plan has a current corrective action plan to address deficiencies. The State monitors the corrective action plans ongoing for improvements and continued deficits. The MyCare Ohio Plans have also been subject to financial penalty and assignment of points. For the second round of reviews in 2017, ODM place a heightened focus on a waiver sub-assurance due to low performance. ODM's increased oversight of this Sub-Assurance indicates continued improvement.
  Program change (system-wide level): After the initial reviews in 2015, ODM updated the evaluation tool and methodology with lessons learned. The updates allowed for a more streamlined approach including the use of an electronic tool, onsite scoring and more defined evaluation criteria. After the tool was modernized, ODM selected "focus" questions. These questions were selected due to priority and/or low performance and linked to compliance actions.

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

_X__ *Clinical*
_X__ *Non-clinical*

Confirmation it was conducted as described:
__x_ Yes
___ No. Please explain:
Summary of results: The initial Chronic Conditions Improvement Project (CCIP) focused on cardiovascular disease. The initial Quality Improvement Project focused on providing long term services and supports in a community rather than institutional setting (nursing home diversion). Each MyCare Ohio plan had the flexibility of
Problems identified: The data submitted focused on barriers and MCP approaches
Corrective action (plan/provider level):
Program change (system-wide level):

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

__x_ *Process*
__X_ *Health status/outcomes* - **The information for this measure is found in C.(c) above.**

__X_ *Access/availability of care*
__X_ *Use of services/utilization*
____ *Health plan/provider characteristics*
___ *Beneficiary characteristics*

Confirmation it was conducted as described:
__ Yes
_X__ No. Please explain:
Summary of results: For the following HEDIS and Medicare Part D process/access & availability/utilization measures, all of the MyCare Ohio plans met or exceeded the minimum performance standard for SFY 2017 (CY 2016 measurement year), except where specified below. Of the 55 total rates (across 11 measures, excluding Plan All Cause Readmission-Observed Readmissions), 72.7% met or exceeded the standard. Measures: Follow-Up After Hospitalization for Mental Illness 30-day visit, Antidepressant Medication Management Effective and Continuation Phase Treatment, Controlling High Blood Pressure, Comprehensive Diabetes Care HbA1c Control (<8.0%), Breast Cancer Screening, Plan All Cause Readmission – Observed Readmissions, Adults' Access to Preventive/Ambulatory Health Services, Care for Older Adults Medication Review/Functional Status Assessment/Pain Assessment, and Part D Medication Adherence for Diabetes Medications. CareSource did not meet the minimum performance standard (≥ 62.8%) for Antidepressant Medication Management Effective

Acute Phase Treatment; CareSource did not meet the minimum performance standard (≥ 39.7%) for Controlling High Blood pressure; all five MyCare Ohio plans did not meet the minimum performance standard (≥ 58.3%) for Comprehensive Diabetes Care HbA1c Control (<8.0%); all five MyCare Ohio plans did not meet the minimum performance standard (≥ 66.3%) for Breast Cancer Screening; CareSource did not meet the minimum performance standards for the three Care for Older Adults measures/rates: Medication Review (≥ 42.3%), Function Status Assessment (≥ 33.6%), Pain Assessment (≥ 45.5%). Note: Plan All Cause Readmission rates are calculated by CMS. Effective for CY 2016, CMS revised the methodology for this measure to an 'Observed to Expected (O/E) Ratio' (instead of the observed ratio rate required by MyCare Ohio). ODM will update MyCare provider agreements to include the O/E Ratio in in order to be consistent with the CMS methodology beginning for future contract periods. The Rebalancing Long Term Care measures (Nursing Facility Diversion and Long Term Care Overall Balance) initially included in the Quality Withhold measure set (i.e. state-specified measures), were suspended (in concurrence with the CMS Medicare-Medicaid Coordination Office/MMCO) effective for SFY 2017 because ODM determined the methodologies may not produce an accurate reflection of the MyCare Ohio population trends over time. Since the inception of MyCare Ohio, there has been a shift away from nursing facility long-term stay utilization and an increase in home- and community-based waiver enrollment. This trend was not reflected in the rebalancing measure results (including the Overall Balance measure) due to the limitations of the current measure specifications. ODM and MMCO are committed to re-establishing state-specific withhold measures in the near future. The reporting of the results for the other Improving Long Term Care/Nursing Facility measures has been delayed due to data source issues with the Ohio long-term care facility Minimum Data Set (MDS).

Problems identified: n/a
Corrective action (plan/provider level): n/a
Program change (system-wide level): n/a

Health plan stability/financial/cost of care

Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain:

Summary of results: On a quarterly basis ODM and its actuary review the financial results reported by the plans via their cost reports, any deficiencies are reported to the plan for explanation or correction.

Problems identified: No
Corrective action (plan/provider level): No
Program change (system-wide level): No

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**

_X__ *Survey of providers (Ohio Medicaid Managed Care Provider Satisfaction Survey Report (Primary Care Providers))*

___ *Focus groups*

Confirmation it was conducted as described:

___ Yes

_X__ No. Please explain: This activity was not described in the previous waiver submission because ODM did not conduct this non-mandatory activity until 2018. The 2018 survey provides baseline survey findings.

Summary of results:

Overall, 561 providers completed the Provider Satisfaction Survey, an 8.5 percent response rate. Over 48 percent of the respondents were from a family practice and nearly 55 percent of respondents were affiliated with an independent private practice. The majority of the respondents (67 percent) reported that they have been in practice for 16 or more years. Survey respondents primarily were a physician or an office manager, 44 percent and 39 percent, respectively. Approximately 30 percent of the survey respondents were CPC providers.

Results of the 2018 Provider Satisfaction Survey revealed that respondents' satisfaction for nine of the 10 core measures was below 50 percent. Over half of the providers are not satisfied with the Medicaid plans (nearly 52 percent). Respondents' satisfaction was the lowest for the following three measures: prior-authorization process (approximately 30 percent), assistance in improving health outcomes (approximately 34 percent), and provider relations (approximately 36 percent). The only measure that exceeded 50 percent was the ability to obtain member-level information (approximately 54 percent).

The low level of satisfaction with the prior-authorization process is also consistent with the open-ended comments provided. Respondents provided the highest percentage of open-ended comments (almost 29 percent) related to their dissatisfaction with the prior-authorization process. The current prior-authorization process is cumbersome and takes the providers away from patient care. Other areas of concern identified through the open-ended comments that were not directly measured by this survey included the Medicaid plans' formularies and reimbursement.

The comparative analysis of the CPC and non-CPC providers' mean scores revealed statistically significant differences between the populations. The CPC providers' mean scores were statistically significantly lower than the non-CPC provider for four of the 10 measures (Ability to Obtain Member-level Information, Prior-Authorization Process, Provider Portal, and Assistance in Improving Health Outcomes).

Problems identified: No systemic issues were identified through this review of baseline survey results.

Corrective action (plan/provider level): No corrective actions were taken as a result of this review.
Program change (system-wide level): No program changes were made as a result of this review.

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 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 five-year waiver period, called Prospective Year 1 (P1), Prospective Year 2 (P2), Prospective Year 3 (P3), Prospective Year 4 (P4) and Prospective Year 5 (P5). 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 five-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:
Roxanne Richardson

c. Telephone Number: 614.752. 0503

d. E-mail: Roxanne.Richardson@medicaid.ohio.gov

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

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

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

b.__X_The State makes enhanced payments to contractors or providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

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

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

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

d. ___ [Required] Explain any other variance in eligible member months from BY to P5:

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 through R5 data is the population under the waiver.

b._X___ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R5 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 R5 of the previous waiver period.

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

_____

The State is using the following description for each Medicaid Eligibility Group (MEG):

Institutional MEG - Represents enrollees who meet a nursing facility (NF) level of care (NFLOC) standard and are long term nursing facility (NF) residents with 100 or more consecutive days in a NF.

Community Waiver MEG - Represents enrollees who meet a nursing facility (NF) level of care standard and are enrolled in one of the Ohio home- and community-based waiver programs.

Community Well MEG - Represents enrollees who do not meet a nursing facility (NF) level of care standard or are determined to no longer need NFLOC services.

These MEGS were selected for two reasons:

1. ***The HCBS waiver enrollees are required to have a stand-alone MEG because they are entitled to a different benefit package than the other MEGs. All HCBS waiver enrollees are in the Community Waiver MEG.***
2. ***The State considered the risk variation in the various populations along with ease of operationalization in determining the other two MEGs. Costs for individuals living in institutions are reported in the Institutional MEG because their costs are significantly different than the costs of individuals not meeting nursing facility level of care, whose costs are reported in the Community Well MEG.***

The R1 and R2 experience represents current waiver year (WY) 3 and WY 4 actual experience across the 3 MEGs. The projection of future member months was based on current trends among the three Medicaid Eligibility Groups (MEGs) as well as anticipated population changes in CY 2019. The assumed growth rates reflect expected increases in the Medicaid target population and the aging of the Medicaid population.

The membership projections for CY 2019 (P1 of the future waiver period) assume enrollment annualized growth of 4.0% from the most recent quarter of actual experience. This growth reflects changes in the population for Specialized Recovery Services (SRS) recipients and additional dual enrollment expected in CY 2019. Future enrollment growth for P2-P5 is expected to grow at approximately 1.0% per year. The enrollment growth assumptions are representative of current trends and the anticipated shift in future enrollment mix away from institutions into community care.

d. _X__ [Required] Explain any other variance in eligible member months from BY/R1 to P5: _ Other increases from the original base year were due to ramp-up of enrollment for the new waiver ___

e._X___[Required] Specify whether the BY/R1/R2/R3/R4/R5 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _ ***Retrospective years represent current waiver periods____***.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a._X__[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: __ ***There are no additional services being included in the new waiver period***

_____

b._X__[Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: __ ***There were no services excluded from the cost-effectiveness analysis.***_____

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 through R5 or BY.*

For Initial Waivers:

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

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

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

The State allocated administrative costs to this MCO waiver based on the percentage of eligible population for this waiver when compared to the total Medicaid eligibles statewide. The administrative costs associated with this waiver were reported in the CMS 64.10 reports over the course of the waiver period.

ICDS plan administrative costs, which vary greatly from the low-income child and adult populations, are included in capitated rates per 42 CFR 438.812 and treated as services costs under the 1915(b) waiver cost-effectiveness. These costs are reported in the CMS 64 claiming in the capitated rates and under the services costs in the renewal waiver.

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

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

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

Waiver Cost Projection for P1 through P5 on **Column W in Appendix D5**.

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

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

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 through R5 (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 through P5 on **Column W in Appendix D5**.

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

Basis and Method:

1._X__ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to

purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

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

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

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

For each individual who transitions from a nursing facility or community waiver with a nursing facility level of care to a community placement and improved overall health outcomes such that the individual no longer meets nursing facility level of care, the State will award an incentive payment to the ICDS plan equal to the differential between the community well capitation payment and the nursing facility level of care capitation payment for that individual for three months. In order to maintain cost-effectiveness of the waiver and create a disincentive for placing individuals in nursing facilities, the ICDS plan will be penalized for each individual entering a nursing facility by being paid a payment less the differential between the community well capitation payment and the nursing facility level of care capitation payment for that individual for three months. The waiver cost projections are not exceeded because as members move from the Institutional and Community Waiver MEGs to the Community Well MEG, the incentive is less than cost of the differential (i.e., each individual moving from one MEG to the other is a savings in the aggregate cost-effectiveness). On a PMPM basis, the payments to the ICDS plan for the transitioned population are less than overall MEG PMPM for the Community Well.

The State and CMS under this demonstration will be working with any individual to ensure that appropriate care regardless of which setting is provided and that it will not lead to unnecessary inpatient admissions. This is consistent with the tenets of the

Olmstead decision that with an adequate level of supports, any individual may live in the setting of their choice and not be institutionalized. Each individual who no longer is eligible for the HCBS waiver will be permitted to appeal the decision through the normal State Fair Hearing process.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

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

Current Initial Waiver Adjustments in the preprint

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

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 through P5. 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 (P5). 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 through P5 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_ _____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

3.____The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 through P5.

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 through P5 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 P5. 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).

B.____Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend

between the beginning of the program (P1) and the end of the program (P5). 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 P5. 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 P5 (please describe).

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

Method:

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

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

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

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

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not 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._X__No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH

payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

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

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
1. _X_ This adjustment is not necessary as there are no voluntary populations in the waiver program.
1.___ 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. _X_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

The State has made an adjustment to the base data to remove the prospective cost component from the payments made to FQHCs/RHCs during the capitation rate development process.

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.

c. Not applicable for an initial application utilizing FFS data for projections.

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.

1.___ 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 through P5 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.

  1.___ 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 through R5 (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 R5 (BY for conversion) to the end of the waiver (P5). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1._X__[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: ***_0.5% for Institutional and Community Waiver MEGs and (1.2%) for Community Well*** **_____**. Please document how that trend was calculated:

A program adjustment is reflected in Column M of D5 to reflect the actual capitation rate changes that took place in CY 2018 from CY 2017. This adjustment was necessary to fully adjust the R2 experience to CY 2018 values. Additional estimated trend was applied to adjust for CY 2019 and future as reflected in the State Plan Inflation adjustment of Column K in D5.

The adjustments reflected in Column M represent actual changes from CY 2017 to CY 2018 in the NFLOC (Institutional and Community Waiver MEGs) and the Community Well capitation rates. These changes were adjusted to account for the fact that Q1 2018 (January to March 2018) is included in the R2 12-month experience.

2._X__[Required, to trend BY/R2 to P1 through P5 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. _X___ State historical cost increases. Please indicate the years on which the rates are based: base years_ ***CY2016-2018 specific to this waiver*** _____ 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's expenditure reports, health plan encounter data and historical capitation rates were the primary sources used by the actuary for determining trend for the prospective periods for this waiver request. The State considered historical year over year trends in developing trend estimates and also changes to the waiver program, consistent with the development of capitation rates. The actuary utilized a linear regression looking at experience on rolling twelve-months.

For the prospective time periods (P1 to P2, P2 to P3, P3 to P4 and P4 to P5), the State assumed an overall 4.0% annual trend across all MEGs. This trend rate considers multi-year projections as this constitutes a 5-year waiver renewal. The same rate is paid to the ICDS plans for both the Institutional and Community Waiver MEGs, which combined represent individuals that meet the NFLOC requirement.

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 through P5.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

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

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

Others:

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

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS

claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

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

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

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

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

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

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

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

D.____Other (please describe):

vi.__ X 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.____X Other (please describe):

A program adjustment is reflected in Column M of D5 to reflect the actual capitation rate changes that took place in CY 2018 from CY 2017. These adjustments were necessary to fully adjust the R2 experience to CY 2018 values. Additional estimated trend was applied to adjust for CY 2019 and future as reflected in the State Plan Inflation adjustment of Column K in D5.

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

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

2._X__An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P5. Please describe:

ii._X__ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C._X___State Historical State Administrative Inflation. The actual trend rate used is: __***3.0%***_____. Please document how that trend was calculated:
State administrative inflation was based on historical salary increases in the State of Ohio over recent time periods.

D.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are

unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P5). 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 P5. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

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

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

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

3. Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 through P5 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated. *Basis and Method:*

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

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

3.___ Other (please describe):

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

K. Appendix D5 – Waiver Cost Projection
The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets
The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

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

      The R1 and R2 experience represents current waiver year (WY) 3 and WY 4 actual experience across the 3 MEGs. The projection of future member months was based on current trends among the three Medicaid Eligibility Groups (MEGs) as well as anticipated population changes in CY 2019. The assumed growth rates reflect expected increases in the Medicaid target population and the aging of the Medicaid population.

      The membership projections for CY 2019 (P1 of the future waiver period) assume enrollment growth of 4.0% annualized increase from the most recent quarter of actual experience. This growth reflects changes in the population for Specialized Recovery Services (SRS) recipients and additional dual enrollment expected in CY 2019. Future enrollment growth for P2-P5 is expected to grow at approximately 1.0% per year. The enrollment growth assumptions are representative of current trends and the anticipated shift in future enrollment mix away from institutions into community care.

   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**:

      The State did not estimate cost changes separate from utilization changes. Utilization did not duplicate separate cost increase trends. Utilization trend is considered in the State's overall analysis of trend.

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**:

   The State's expenditure reports, health plan encounter data and historical capitation rates were the primary sources used by the actuary for determining trend for the prospective periods for this waiver request. The State considered historical year over year trends in developing trend estimates and also changes to the waiver program, consistent with the development of capitation rates. The actuary utilized a linear regression looking at experience on rolling twelve-months.

   For the prospective time periods (P1 to P2, P2 to P3, P3 to P4 and P4 to P5), the State assumed an overall 4.0% annual trend across all MEGs. This trend rate considers multi-year projections as this constitutes a 5-year waiver renewal. The same rate is paid to the ICDS plans for both the Institutional and Community Waiver MEGs, which combined represent individuals that meet the NFLOC requirement.

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.

Attachment 1

Instructions for

Section 1915(b) Waiver Preprint
For

- MCO, PIHP, PAHP, PCCM Programs

And

FFS Selective Contracting Programs

July 18, 2005

MMA amendment version

Draft

Preprint Instructions

Introduction

This waiver preprint is for a State's use in requesting authority under section 1915(b) of the Social Security Act (the Act) to operate a managed care program. Specifically, it is designed for use in authorizing programs involving Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) systems. In addition, it can be used for section 1915(b)(4) fee-for-service selective contracting programs. Use of this 1915(b) waiver preprint is strongly encouraged.

Section 1915(b) of the Act, and 42 CFR 431.55, require that states assure waivers under this authority are cost-effective, and do not substantially impair access to services of adequate quality where medically necessary.

This waiver preprint is organized as follows:

Face Sheet	Key Information
Section A	Program Description
Section B	Monitoring Plan
Section C	Monitoring Results
Section D	Cost effectiveness
Appendices D1-7	Cost effectiveness data

This preprint incorporates relevant statutory requirements (see sections 1902, 1903, 1915, and 1932 of the Act), as well as pertinent regulations (see 42 CFR Parts 431, 434, and 438). Please note that states must still have MCO contracts and capitation payments prior approved by the CMS Regional Office, and must have PIHP and PAHP contracts and capitation payments reviewed and approved by the CMS Regional Office.

This preprint is not for use in authorizing managed care programs under sections 1905(t), 1915(a), or 1932(a) of the Act. Programs under those authorities are authorized through state plan amendments.

Features

This waiver preprint is designed to simplify the waiver application process. It has the following features:

- Use same document for initial and renewal. The State may use this waiver preprint to make an initial request to authorize a new 1915(b) waiver program, or to request a renewal or amendment of an existing one. In addition, Sections A

and B (Program Description and Monitoring Plan) need not be resubmitted at each renewal if there are few or no changes.

- Authorize multiple programs. The preprint is flexible enough to be used to authorize multiple managed care programs under a single waiver request. However, it is up to States to determine how many waiver programs they want to authorize in a given waiver request.
- Reduce duplication with other requirements. Federal regulations in 42 CFR 438 provide clear and consistent requirements related to beneficiary protections for all types of managed care programs; and for access and quality for capitated programs. As a result, in many places assurances of compliance with regulatory requirements will be sufficient to comply with waiver requirements related to Program Impact, Access, and Quality. Additional information may be required if a State requests a waiver of a provision within the regulation.
- Provide clear evaluation criteria. The preprint provides clear direction on the information needed and criteria used to evaluate waiver requirements related to Program Impact, Cost Effectiveness, Access, and Quality.

How to submit

What to include in submission. For initial or renewal requests, submit the items below. For amendments, see the next section.

- Signed cover letter (from the Governor, state cabinet members responsible for state Medicaid activities, the Director of the state Medicaid agency, or someone with authority to submit waiver requests on behalf of the Director)
- Face sheet
- Sections A-D (as applicable; see below)
- Appendices D1-7 (as applicable; see below)
- Any other state-specific attachments.

Number of copies/format. Please submit the following to the CMS Central Office:

- One original hard copy of the waiver preprint and attachments
- One electronic copy of the waiver and any attachments available electronically
- Four (4) copies of any waiver attachments not available electronically

At the same time, send at least one hard copy of the waiver request to the appropriate CMS Regional Office.

Where to send. For MCO programs, PCCM programs, PAHP programs covering dental or transportation services, and FFS selective contracting programs:

CMS, Center for Medicaid and State Operations
Attn: Director, FCHPG, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For PIHP/PAHP programs focusing on behavioral health, or on elderly and disabled populations:

CMS, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

Processing timelines. CMS must approve, disapprove, or request additional information for a waiver request submitted under section 1915(b) of the Act within 90 days of receipt, or else the request is deemed granted. When CMS requests additional information, the waiver request must be approved or disapproved within 90 days of CMS' receipt of the State's complete response to the request for additional information, or the waiver request is deemed granted. The 90-day time period begins (i.e., day number one) on the day after the day the State's waiver or response to request for additional information is received by the addressee (i.e., the Secretary, the CMS Central Office, or CMS Regional Office designee) and ends 90 calendar days later.

When Amendment Needed During Waiver Period

The State must submit an amendment for major changes, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, PCCM quality/access, monitoring plan, changes in payment rates, or changes in costs or trends that may jeopardize cost-effectiveness. Please submit replacement page(s) for relevant changes.

The same timelines and procedures described in the "How to Submit" section above apply to waiver amendments. Approval of a request to amend the waiver is effective from the date of approval through the end of the renewal period. The request must be submitted and approved prior to implementation of a change in the waiver program.

Instructions for Filling Out Sections A, B, and C

General instructions for filling out Sections A, B, and C are below. Each Section may have more detailed instructions. The preprint clearly indicates if a given item only applies to a certain type of managed care entity. If a given item does not apply, the State should indicate this by inserting "not applicable."

Assurance of compliance with requirements. The preprint includes assurances with compliance with applicable federal statutory, regulatory, and policy requirements related to managed care.

Exception: If the State is requesting a waiver of a provision of a federal managed care requirement, it must add language at the end of the assurance stipulating the waiver being requested, and what, if anything, the State will do instead.

Detail on discretionary items. In areas where the State has discretion, the State must describe what method it uses. For example, 42 CFR 438.10(c)(1) requires the State to identify prevalent non-English languages, but gives the State discretion in what

methodology to use. For PCCM programs, the State has broader discretion in demonstrating how the waiver program impacts access and quality, so must describe in detail the standards and processes it uses.

Initial waiver request. If this is an initial waiver request, the State should fill out Sections A (Program Description), B (Monitoring Plan), D (Cost-Effectiveness) and Appendices in full. In Section C (Monitoring Results), the State must assure that in the renewal request, it will submit the results of its monitoring activities.

Renewal waiver request -- converting to new preprint. If this is the first time a State is using this preprint format, the State should fill out the preprint in full.

Renewal waiver request – once new preprint has been used. If the State has used this format for the previous waiver period, the State should fill out Sections C and D (Monitoring Results and Cost-Effectiveness) and Appendices D1-7 of the preprint in full. With respect to Sections A-B (Program Description and Monitoring Plan), the State has two options:

Option 1 – Submit sections in full. The State may want to consider this if there are numerous changes from how the program was operated and/or monitored compared to the previous waiver period.

Option 2 – Carry over from previous waiver period. If there are few or no changes to the Program Description or Monitoring Plan, the State need not re-submit these sections. Instead, it can indicate it will use the same Sections from the previous waiver period, and if needed, submit replacement pages for minor changes.

The State may choose different options for Section A versus Section B. Please indicate on the Facesheet which option the State uses.

Single program. Many areas of the preprint apply to all entity types (e.g. enrollment, information). However, if a given section does not apply to the type of entity in a single program waiver, please respond by inserting "Not Applicable."

Multiple programs. This preprint can be used for a combination of capitated and PCCM programs. However, not all programs will fit each item, or the answer to a given item may be different for PCCM versus a capitated program. If the State's response differs for either the capitated or PCCM program, please check the box if applicable and add narrative below to describe to which program(s) the checked box applies and how.

FFS selective contracting programs. If a State is only using section 1915(b)(4) authority to selectively contract FFS providers (i.e. who do not qualify as an MCO, PIHP, PAHP, or PCCM), the portions of the preprint that require assurances with managed care regulations and contracts do not apply. However, the State must still address program impact, access, and quality, though they have discretion in how to do so. Please fill in the "1915(b)(4) FFS selective contracting" items within each section.

MMA 1915(b) Amendment Instructions

Any drug costs for Dual Eligibles that are in the waiver cost-effectiveness and no longer covered by Medicaid will need to be adjusted out of the 1915(b) waivers as of 1/1/2006.

Option 1: You may do this through a Waiver renewal submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1 adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

or

Option 2: through an extra amendment to your waiver submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1 adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

Qs and As from States regarding the modification to 1915(b) waivers

Q1: Since Medicaid must pay the federal government back for the amount of drug payments that Iowa paid for dual eligibles in 2003 after implementation of Medicare modernization, we are not sure that there will be any less amount that Medicaid paid for drugs. It is more indirect than before when Medicaid paid the costs directly, but the incidence is for drugs when we have to pay back the federal government. Also we will lose the drug rebate for the drugs we paid, which again we think may mean no savings to Medicaid for Medicare paying drugs for the dual eligibles.

A1: The calculation of state contribution and the overall cost to the State will not count against the waiver cost-effectiveness in future 1915(b) waivers. These are separate calculations.

Instructions for Filling Out Section D – Cost Effectiveness

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. Instead, 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.

The 1915(b) Cost-Effectiveness Instructions are divided into 3 major sections:

Section I.	Definitions and Terminology
Section II.	General Principles of the Cost-Effectiveness Test
Section III.	Instructions for Appendices

In addition there are seven Appendices:

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. The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska's actual experience or program structure.*

In addition, technical assistance is available through each State's CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

Actual Waiver Service Cost + Actual Waiver Administration Cost<= Projected Waiver Cost

I. Definitions and Terminology

The following terms will be used throughout this document and are defined below:

For Initial Waivers:

Historical Period

- BY = Base Year

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Conversion Waivers *(existing waivers which will "convert" from the former "with and without waiver" cost effectiveness test to the new cost effectiveness test described in these instructions)*:

Historical Period for first time a State completes the new cost effectiveness test

- BY = Base Year – CMS prefers 7/1/2001 – 6/30/2002

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Renewal Waivers:

Retrospective Waiver Period

- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

Form CMS-64: *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (MBES - formerly known as the HCFA-64) submitted by States as an accounting statement under Title XIX and Title XXI of the Social Security Act. The *Form CMS 64* is completed according to the reporting instructions in the State Medicaid Manual, Section 2500. Additional technical assistance is available through each State's CMS Regional Office. Each Regional Office will have a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests. In general, CMS-64 data is recorded based on the date that a payment was made to a provider.

Form CMS-64 Summary and CMS-64.9:

The *Form CMS-64 Summary* is an accounting of all expenditures for Medical Assistance **services and administration** for both MAP (CMS-64.9) and ADM (CMS-64.10) under Medicaid Title XIX and Title XXI Medicaid Expansion Groups including waiver expenditures. The Summary Sheet is generated from all worksheets entered by the State in support of each line item (including prior period adjustments). The *CMS-64.9* reports current expenditures for Medical Assistance **services** under the non-waiver programs.

Form CMS-64.10: The *Form CMS-64.10* is an accounting of **administrative** expenditures in Medicaid Title XIX for non-waiver programs.

Form CMS-64.21U: The *Form CMS-64.21U* is an accounting of **service and administrative** expenditures for the State Medicaid Expansion portion of the Children's Health Insurance Program (SCHIP) Title XXI. This form reports expenditures for children covered under 1905(u)(2) and (u)(3) of the Social Security Act.

Form CMS-64 F:

The *CMS-64 F Form* recaps all *CMS-64.21 Medicaid Expansion Forms* and Medicaid *CMS 64.9 Forms*. The *CMS-64 F Form* is summarized in the *CMS-64 Summary Form*. The *CMS-64 F* describes the source of the data on each line of the *CMS-64 Summary*. An example follows:

CMS-64 Summary, Line 6 MAP = $100

CMS-64 F, Line 6 MAP, *Form CMS-64.9* = $80
CMS-64F, Line 6 MAP, *Form CMS-64.21* = $20

Form CMS-64.9 Waiver: Same as the *Form CMS-64.9* except the *Form CMS-64.9 Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver program. The State will provide separate *CMS-64.9 Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.9 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.9 Waiver form* for expenditures that are not included on other *64.9 Waiver forms*. The *CMS-64.9 Waiver forms* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.9 Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.9 Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.9 Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.9 Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instruction section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the following Standard 1915(b) Waiver coding system:

- State Code: This will be the State's two-digit identifier (e.g., CA, FL, PA);
- Two digit waiver number;
- Followed by the two-digit waiver renewal number; and
- Followed by the two-digit consecutive waiver year.

Please work with your RO if you need guidance identifying this number. *Example: The Iowa Plan reporting for a waiver renewed on July 1, 2001 would use: IA07.R02.05. The Iowa Plan is Iowa's seventh waiver. It was renewed for the second time on July 1, 2001. If the first year of their waiver began July 1, 1997, the waiver year beginning July 1, 2001 would be 05.*

State Code	IA
Two-digit waiver number	07
Two-digit waiver renewal number	02
Two-digit consecutive waiver year	05

Form CMS-64.9P Waiver: Same as the *CMS-64.9 Waiver* except reporting a prior period adjustment.

Form CMS-64.10 Waiver: Same as the *Form CMS-64.10* except the *Form CMS-64.10 Waiver* reports Administration costs only for the population and services covered by the State's 1915(b) waiver program. The State will provide separate *CMS-64.10 Waiver forms* for each 1915(b) waiver program. The State must report administrative costs attributable to each waiver program on separate *CMS-64.10 Waiver forms*. Administrative costs that are applicable to more than one waiver program must be allocated to the respective *CMS-64.10 Waiver forms* based on a method approved by CMS (e.g., allocation based on caseload or Medical Assistance payments). Therefore, the *CMS-64.10 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If the State has specific questions regarding this requirement, please contact your State's RO. To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system. *Note: States should document their cost allocation methodology for administration costs between waivers in D.I.G.*

Form CMS-64.10P Waiver: Same as the *CMS-64.10 Waiver* except reporting a prior period adjustment.

Form CMS-64.21U Waiver: Same as the *Form CMS-64.21U* except the *Form CMS-64.21U Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver programs. Cost Effectiveness requirements apply only to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program. The State will provide separate *CMS-64.21U Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.21U Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.21U Waiver form* for expenditures that are not included on other *64.21U Waiver forms*. The *CMS-64.21U Waiver sheets* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.21U Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.21U Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.21U Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.21U Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instructions section in the Technical Manual for that circumstance. If the

State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system.

Form CMS-64.21UP Waiver: Same as the *CMS-64.21U Waiver* except reporting a prior period adjustment.

Schedule D: Schedule D is a report of waiver expenditures by waiver year for a given waiver period that is generated within the Medicaid Statement of Expenditures for the Medical Assistance Program (MBES) when selected by an MBES user from the reports menu. The State will submit a Schedule D for the previous waiver period with each renewal submission.

Base Year: In an Initial Waiver (i.e., first submission of a new program's cost-effectiveness data), CMS requires all States to create a BY which can be used to project total expenditures for the projected waiver period (P1 and P2). The BY must be the most recent year that has already concluded. The State must justify the use of any other year as the base year. All expenditures in the BY will be verified by the RO. The BY expenditure and enrollment data should be the actual experience specific to the population covered by the waiver. The maximum time period between a BY and P1 should be five years. CMS recommends that States use the first day of a Federal quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Base Year for Conversion Waivers: In Conversion Renewal Waivers (i.e., existing 1915(b) waivers which will comply with these cost-effectiveness instructions ***for the first***), CMS will require all States to create a BY which can be used to project total expenditures for the projected waiver periods (P1 and P2). If possible, the BY should be a year which has already concluded and where no additional payments can be recorded. All expenditures in the BY will be verified by the RO. CMS prefers that states use 7/1/2001 – 6/30/2002 as their BY because it was prior to the announcement of the new test and would not allow states to increase costs after the announcement that there would be no retrospective review for the conversion renewal period. That base year is also complete and allows states to begin analysis in order to submit their waivers in a timely manner. If the State would like, CMS will negotiate a BY that has already been concluded other than 7/1/2001 – 6/30/2002. For waivers just renewed in 2003 under the old methodology, if a State begins reporting waiver expenditures by MEG in a timely fashion, the State may have a full year of data on the MBES system via the CMS-64 Waiver forms by the time the waiver is renewed in 2005. If this is the case, the State could use the Schedule D information for a waiver year in the most recent waiver period to complete their upcoming renewal. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date. *Note: For the first renewal of an initial*

waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to adding into waiver cost projections.

Caseload: The total number of individuals enrolled on a waiver at any given time is its caseload. Because cost-effectiveness is calculated on a PMPM, the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload. The standard measurement for caseload is member months.

Case mix: The payments and the PMPM costs of a waiver program are affected by the distribution of the caseload among different reporting categories (MEGs in a 1915(b) waiver). The relative distribution of a member months among MEGs is referred to as membership mix or "case mix". Anytime a State has a MEG with greater than average cost and a caseload growing at a faster rate than less expensive MEGs, the overall weighted average should account for casemix changes or there will be a false impression of the waiver not being cost-effective. *For example, in a State with 100 enrolled members, MEG 1 has a PMPM cost of $3,000 and has 25% of the member months (25 member months) in the base year. MEG 2 has a PMPM cost of $300 and has 75% of the member months (75 member months) in the base year. The overall weighted PMPM for BY with the base year casemix would be:*

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{BY PMPM x BY MM}}{\text{BY MM}}$ =BY PMPM With Casemix for BY

The State projects that the casemix and costs will remain the same in the future (P1). However, if in P1, the program's casemix changes so that MEG 1 has 30% of the member months and MEG 2 has 70% of the member months in P1. The overall weighted PMPM for P1 with the P1 casemix would be:

$\frac{(\$3000 \times 30) + (\$300 \times 70)}{100} = \$1{,}110$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$ =P1 PMPM With Casemix for P1

In this case, because MEG 1 has a high cost, a relative distribution change from MEG2 to MEG 1 artificially inflates the PMPM if the State does not account for the changes in the casemix. The overall weighted PMPM for P1 with Casemix for BY

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$ =P1 PMPM With Casemix for BY

Throughout this document, CMS has explained when to account for casemix changes and how to calculate those calculations. In determining whether to renew the waiver, States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. However, for the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one which accounts for casemix changes (to monitor for PMPM waiver cost-effectiveness) and another which does not account for casemix changes (to monitor for overall growth in CMS-64 expenditures). These calculations are projected in Appendix D6 and explained in the instructions and Technical Assistance Guide.

Medicaid Eligibility Group (MEG) - A MEG is a population reporting category usually determined by eligibility group, geography, or other characteristics that would

appropriately reflect the services that will be provided. Each State will have at least one Title XIX MEG for a Medicaid 1915(b) waiver. If the State includes MCHIP populations under 1905(u)(2) and/or (u)(3) in the 1915(b) waiver, then the State will also have at least one Title XXI MEG. Each MEG's costs will be reported on a separate 64.9 Waiver Form (64.21U Waiver Form if the MEG is for an MCHIP population). States are held accountable for member month distribution changes within MEGs, but not between MEGs. In cases where significantly different costs exist between different populations, the State should consider separate MEGs to account for the likelihood of a change in the proportion of the enrollees being served in any single reporting group. The State should recognize the impact on cost trends of the increase in the proportion of membership, which would be associated with the higher cost group when determining cost-effectiveness. The State may want to consider a more complex reporting structure, which would attempt to recognize high-cost groups separately from low-cost groups. It is in a State's interest to group populations with similar costs and similar caseload growth together. *For example, a State has a program with 100 member months - 25% of which cost $3,000 and 75% of which cost $300. The State can choose to have a single MEG with a PMPM cost of $975 or two MEGS with a weighted PMPM of $975. If the State has a distribution shift between the two population groups so that there are relatively more expensive persons costing $3,000, the State will be held accountable for that redistribution effect if it has only one MEG and will not be held accountable if the State has two MEGS. The weighted-average PMPM Casemix for BY for the single MEG is $1,110. The weighted-average PMPM Casemix for BY for two MEGs is $975.*

One MEG

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) / 100	*= 975*	*($3000 x 30) + ($300 x 70) / 100*	= $1,110
BY PMPM x BY MM / BY MM	=BY PMPM With Casemix for BY	P1 PMPM x P1 MM / BY MM	=P1 PMPM With Casemix for BY

Two MEGs

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) / 100	*= 975*	*($3000 x 25) + ($300 x 75) / 100*	= 975
BY PMPM x BY MM / BY MM	=BY PMPM With Casemix for BY	(P1 PMPM x BY MM) + (P1 PMPM x BY MM) / BY MM	=P1 PMPM With Casemix for BY

Adjustments: Each State creates budget projections in a slightly different manner than other states. To address this, CMS has identified the most common adjustments states make to base year data (in initial and conversion waivers) and R2 data (in renewal waivers). The State must document each adjustment made, what is meant by each adjustment in the State Completion Section, how that adjustment does not duplicate another adjustment made, and how each adjustment was calculated. For example, in the State Completion section, the State is asked to document the State Plan Services Trend

Adjustment. The State Plan Services Trend Adjustment reflects the expected PMPM cost and utilization increases (e.g., service prices, practice patterns, and technical innovation) in the managed care program from R2 (BY for initial/conversion waivers) to the end of the waiver (P2). Trend adjustments may be State Plan service-specific. Adjustments are typically expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states may calculate a combined trend rate. Because the trend is expressed on a PMPM basis, the State should explain what is accounted for in the trend adjustment (i.e., cost and utilization increases). Any trend should not be duplicated in the State's adjustments for programmatic/policy/pricing adjustments. For example, a Legislative price increase would be explained and reflected in the programmatic/policy/pricing adjustment not under the State Plan Services Trend Adjustment. The State should document how the adjustments are unique and separate.

Trend: Growth in spending from one year to the next year. Growth may be due to cost and utilization increases. Growth due to external forces such as Legislative change or program/contract change should be documented separately under adjustments that include more than trend. If only a trend adjustment is allowed, then growth due to external forces is not allowed without a separate waiver amendment documenting additional savings. In this preprint, all adjustments are made on a PMPM basis. For the sake of simplicity, whenever trend appears alone it refers to a PMPM increase in the cost.

Comprehensive Waiver Criteria: When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test: 1) Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority; 2) Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc); or 3) State Plan services were procured using sole source procurement.

Expedited Test: States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. To be able to use the Expedited Test for a particular waiver, a State would need to submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria (see above) OR Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver, which meets the Comprehensive Waiver Criteria except for the transportation and dental waivers specifically exempted.

Projections in Renewal Waivers: In Renewal Waivers, State will use its actual experience R1 and R2 data to project its P1 and P2 expenditures from the endpoint of the previous waiver of R2. In each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver

submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Projected Waiver Period: P1 and P2 are projections of the Medicaid waiver program expenditures for the future two-year period for the population covered by the waiver.

Retrospective Waiver Period: R1 and R2 are the actual Medicaid waiver program expenditures in the historical two-year period for the population covered by the waiver. These R1 and R2 costs are compared to the P1 and P2 projections from the previous waiver submission. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to developing waiver cost projections.*

1915(b)(3) service: An additional service for beneficiaries approved under the waiver paid for out of waiver savings. The service is not in the State's approved State Plan. Capitated 1915(b)(3) services must have actuarially sound rates based only on approved 1915(b)(3) services and their administration subject to RO prior approval.

Acronyms used in this section
ADM - Administration
AI/AN – American Indian/Alaskan Native
BBA – Balanced Budget Act of 1997
BY – Base Year
CAP - cost allocation plan amendment
CE – Cost Effectiveness
CMS – Center for Medicare & Medicaid Services
Co. - County
CSHCN – Children with Special Health Care Needs
CY – Calendar Year
DRG - Diagnostic Related Group
DSH - Disproportionate Share Hospital Payments
EQR – External Quality Review
FFP – Federal Financial Participation
FMAP – Federal Medical Assistance Participation
MAP – Medical Assistance Program or services
FFS – fee-for-service
FQHC – Federally Qualified Health Center
FY- Fiscal Year
GME – Graduate Medical Education
HIO – Health Insuring Organization
MBES - Medicaid Statement of Expenditures for the Medical Assistance Program
MCO – Managed Care Organization
MCHIP – Medicaid-Expansion Children's Health Insurance Program
MEG – Medicaid Eligibility Group
MMIS – Medicaid Management Information System
P1 – Prospective Year 1

P2 – Prospective Year 2
PAHP -- Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Manager
PIHP – Prepaid Inpatient Health Plan
PMPM – Per Member Per Month
RHC – Rural Health Center
SPA – State Plan Amendment
PRO – Peer Review Organization
Q1 – Quarter 1
Q4 – Quarter 4
Q5 – Quarter 5
R1 – Retrospective Year 1
R2 – Retrospective Year 2
RO – Regional Office
SCHIP – State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System
Title XIX – Medicaid
Title XXI - State Children's Health Insurance Program
TPL – Third Party Liability
UPL – Upper Payment Limit

II. General Principles of the Cost-Effectiveness Test

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. In order to grant a 1915(b) waiver, a 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. The State will document program expenditures on the CMS- 64 for the same two-year period for the population covered by the waiver. In other words, a State initially projects spending and documents on an on-going basis that the actual expenditures are at or below the projected amount.

In order for CMS to renew a 1915(b) waiver, a State must demonstrate that it was cost-effective during the retrospective two-year period and must create waiver cost projections that will be used to determine cost-effectiveness for the prospective two-year period. The cost-effectiveness test is applied to the combined two-year waiver period, not to each individual waiver year or portion of a year.

The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. States no longer need to demonstrate that "with waiver" costs are lower than "without waiver" costs. Instead, States must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. Retrospectively, the State will document that program expenditures were less than or equal to these projections. As with all elements of 1915(b) waivers, States may amend their cost-effectiveness projections if the waiver program

changes or if additional information documents that the projections are inaccurate and should be modified accordingly.

Each Initial Waiver submission will include a State's projected expenditures for the upcoming two year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2).

For each Renewal Waiver submission, a State will demonstrate cost-effectiveness for the retrospective waiver period by showing that the actual expenditures for retrospective years one and two (R1 and R2) did not exceed what the State had projected it would spend (P1 and P2) for the same two-year period on a per member per month (PMPM) basis for the population covered by the waiver. In other words, a State must compare what it had initially projected it would spend to what it actually spent over the waiver period and show that the actual expenditures came in at or under the projected amount. *Please note that for Conversion Waivers, CMS will not require a retrospective cost-effectiveness test. The State is only allowed a single Conversion Waiver, the first time the State submits a waiver renewal after the announcement of this new method.*

In order to project expenditures for the prospective waiver period, a State must use the actual historical expenditures from its base year (for an initial or conversion waiver) or from the past waiver period (R1 & R2 for a renewal waiver) as the basis for its cost effectiveness projection, adjusting for future changes in trend (including utilization and cost increases), and other adjustments acceptable to CMS. By always using actual historical expenditures from the most recent waiver period as the basis for the projection, the cost-effectiveness test for a waiver program will be "rebased" upon each renewal. *Note: this applies to both capitated and FFS services within 1915(b) waivers. The State must document that actual costs claimed on the CMS-64 were used to document the Actual Waiver Cost in Appendix D3.*

All 1915(b) waivers will use this cost-effectiveness test, regardless of the type of waiver program or the delivery system under the waiver.

All Medicaid Medical Assistance program expenditures (fee-for-service and capitated services) related to the services covered by the waiver will be reported for the population enrolled in the waiver. Because waiver providers can affect the costs of services not directly included in the waiver, CMS is requiring that States include **all Medicaid Medical Assistance program expenditures related to the population and services covered by the waiver, not just those services under the waiver,** in developing their cost-effectiveness calculations. See the detailed instructions below for additional guidance.

CMS will evaluate cost-effectiveness based on all Medicaid expenditures for waiver enrollees impacted by the waiver, even those expenditures that are outside the capitation rate or do not require a PCCM referral. These services are generally referred to as "wrap-around" or "carved-out" services and may include such services as pharmacy or school-based services that may be paid on a fee-for-service (FFS) basis for the population

covered by the waiver. See the detailed instructions below for additional guidance. Additional guidance is also available in the technical assistance guide for cost-effectiveness. Each State will need to work with CMS to determine whether or not services that are not explicitly under the waiver should be included in the cost-effectiveness calculations.

Because all affected Medicaid Medical Assistance program expenditures for waiver enrollees will be counted in cost-effectiveness calculations, there will essentially be no difference in the extent to which services are impacted by either a PCCM system or capitated program cost-effectiveness test. Initial waivers with both PCCM and capitated delivery systems may need to make some specific adjustments in PCCM system expenditures as noted in the **State Completion Section D.I.I Special Note for Capitated and PCCM combined initial waivers**.

State administrative costs associated with the program and population enrolled in the waiver will also be reported. Administrative costs include, but are not limited to, State expenditures such as enrollment broker contracts, contract administration, enrollee information and outreach, State utilization review and quality assurance activities, State hotline and member services costs, the cost of an Independent Assessment, External Quality Review (EQR), actuary contracts, and administrative cost allocation (salaries).

All administrative and service costs should be calculated on a per member/per month basis. States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. States should have total PMPM actual waiver expenditures for the two-year period equal to or less than the corresponding total PMPM projected waiver expenditures for that same period. For the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one examining aggregate projected spending compared to the aggregate CMS-64 totals and the second examining PMPM spending compared to PMPM projections. *See the instructions for Appendix D6 for the explanation of the two calculations and detailed instructions on how to calculate and monitor each test.* **For the ultimate decision of cost-effectiveness (i.e. the decision to renew each waiver), the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.**

Cost-effectiveness will be calculated on a total PMPM basis, which is comprised of both service and administration costs.

CMS will track and evaluate waiver cost effectiveness using expenditure data as reported on the CMS-64 and will be measured in total computable dollars (Federal and State share). All waiver expenditures will be reported on the CMS-64.9 Waiver, CMS-64.21U Waiver, or CMS-64.10 Waiver forms on a quarterly basis. (Data from the CMS-64.21U Waiver form will be used if the State enrolls its Medicaid-expansion SCHIP population in the waiver.)

All expenditures are based on the CMS-64 Waiver forms, which are based on date of payment, not date of service. States will itemize all expenditures for the population covered under the Waiver into each of the main service categories in the CMS-64 Waiver forms. These forms have been cleared by OMB (No. 0938-0067). The *Form CMS-64.9 Waiver* for Medical Assistance payments includes the major categories of service: inpatient hospital services, physician services, dental, clinic, MCO capitation, etc. Administrative expenditures will be reported on the CMS-64.10 Waiver form accordingly. *Note: please ensure that the State's projections for initial, conversion, and renewal waivers are projections for date of payment as well.*

States with multiple 1915(b), 1915(c), and 1115 waivers that have overlapping waiver populations will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the *CMS-64 Summary*.

All actual expenditures reported and used as the basis for a cost effectiveness projection must be verified by the RO.

The expenditures and enrollment numbers for voluntary populations (i.e., populations that can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in State's 1915(b) waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers. If the State wants to include voluntary populations in the waiver, then the expenditures and enrollment numbers for that population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in their waiver are required to submit a written explanation of how selection bias will be addressed in the waiver cost-effectiveness calculations. *Note: This principle does not change the historic practice of requiring States to include the experience of a voluntary MCO population in a mandatory PCCM waiver if a beneficiary can be auto-assigned to one of the delivery systems.*

States with 1932 managed care SPA programs with an overlapping 1915(b) waiver will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the CMS-64 Summary.

Incentive payments will be included in the cost effectiveness test. Incentives included in capitated rates are already constrained by the Medicaid managed care regulation at 42 CFR 438.6(c) to 105% of the capitated rates based on State Plan services. If there are any incentives in FFS/PCCM, those payments must be applied under the cost-effectiveness test. For example, if PCCM providers are given incentives for reducing utilization, the incentives are limited to the savings of State Plan service costs under the waiver. This policy creates a restraint on the FFS/PCCM incentive costs. States should ensure that all incentives are reported in renewal Actual Waiver Costs in **Appendix D3**.

1915(b)(3) waiver services will be included in the cost effectiveness test. In general, States cannot spend more on 1915(b)(3) services than they would save on State Plan services.

Cost Effectiveness requirements apply to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program in the Medicaid delivery system.

Comprehensive Waiver Criteria - When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test:

- Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority,
- Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc), or
- State Plan services were procured using sole source procurement (Sole source procurement means non-open, non-competitive procurement not meeting the requirements at 45 CFR 74.43). States must utilize the Comprehensive Cost Effectiveness Test to apply for and renew 1915(b) waivers that award services contracts using procurement methods meeting the criteria in 45 CFR 74.44 (e). Most competitive procurements resulting in a single contractor are not considered sole-source procurement under the 45 CFR 74.44(e) criteria. The State should verify the regulatory requirements and use the expedited test only if all expedited criteria are met.

Expedited Test – CMS is proposing a waiver-by-waiver test to expedite the processing of certain renewal waivers. States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. States will simply submit *Schedule D* from MBES to CMS along with projections for the upcoming waiver period (**Appendices D1, D2.S, D2.A, D4, D5, and D6 and D7**). For additional guidance, please see the Cost-effectiveness Technical Assistance Manual. To be able to use the Expedited Test for a particular waiver, a State would need to:

- Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria, OR
- Submit a separate 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver that meets the Comprehensive Waiver Criteria except for transportation and dental waivers as noted below.

Cost-effectiveness for waivers of only transportation services or dental pre-paid ambulatory health plans (PAHPs) are processed under the expedited test if the

transportation or dental waiver alone meets the expedited criteria. In this instance, States should not consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. If enrollees in a transportation or dental waiver are also enrolled in pre-paid inpatient health plans (PIHPs), MCOs, or PCCMs under separate waivers or separate SPA authority, the costs associated with dental or transportation services should not be included in any other 1915(b) waiver cost effectiveness test.

III. Instructions for Appendices

Step-by-Step Instructions for Calculating Cost-Effectiveness

Appendix D1 – Member Months

Document member months in the Base Year (BY)/ Retrospective Waiver Period (R1 and R2) and estimate projected member months in the upcoming period (P1 and P2) on a quarterly basis. Actual enrollment data for the retrospective waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed for RO monitoring on a quarterly basis. States will not be held accountable for caseload changes. This data is also useful in assessing future enrollment changes in the waiver.

States must document the number of member months in the waiver for the retrospective waiver period (R1 and R2) for renewal waivers and in the base year (BY) for initial and conversion waivers.

For initial or conversion waivers, document member months from the Base Year (BY). For renewal waivers, document member months from Retrospective Waiver Period (R1 and R2). Categorize all enrollees into Medicaid Eligibility Groups (MEG). A MEG is usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Please note that States will use these same MEGs to report expenditures on the CMS 64.9 Waiver, CMS 64.10 Waiver, and/or CMS 64.21U Waiver.

CMS recommends that the State analyze their capitated program's rate cell categories to support the development of the Medicaid Eligibility Group (MEG) detail within the cost-effectiveness analysis. A MEG is a reporting group collapsing rate cell categories into groups that the State anticipates will have similar inflation and utilization trends, as well as by program structure (eligibility, geography, service delivery, etc). Every MEG created will mean a separate CMS 64.9 Waiver form, etc and results in additional quarterly expenditure reports to CMS. Selecting the right number of MEGs is a very important step. *See the MEG definition above for further guidance.* States should use the 64.9 and 64.21 waiver form population categories for any renewals. *For example, Nebraska chose to divide their single waiver into four MEGs. Nebraska has Medicaid Expansion SCHIP populations in their 1915(b) waiver, which automatically means that 2 MEGs are necessary (one for TXIX and one for MCHIP). In addition, Nebraska chose to*

separate costs for Special Needs children's populations and AI/AN populations from all other enrollees because of the structure of their program and differential caseload trends that they anticipate. During the waiver, Nebraska will report waiver costs on two separate 64.9 Waiver forms ((Medicaid (No CSHCN or AI/AN – PIHP only), and Medicaid (CSHCN or AI/AN– MCO/PIHP/PCCM) and two separate 64.21U Waiver forms (MCHIP (No CSHCN or AI/AN– PIHP only), MCHIP (CSHCN or AI/AN – MCO/PIHP/PCCM)). In Nebraska's renewal they would have a MEG for each of the four populations).

Step 1. List the Medicaid Eligibility Groups (MEGs) for the waiver. List the base year eligible member months by MEG. Please list the MEGs for the population to be enrolled in the waiver program. The number and distribution of MEGs will vary by State. For renewals, if the State used different MEGs in R1 and R2 than in P1 and P2, please create separate tables for the two waiver periods (the State will be held accountable for caseload changes between MEGs in this instance). The base year for an initial waiver should be the same as the FFS data used to create the PMPM Actual Waiver Costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted in the Appendix and explained in the State Completion Section of the Preprint.

Step 2. Project by quarter, the number of member months by MEG for the population that will participate in the waiver program for the future waiver period (P1 and P2). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in R1 and R2. List the quarterly member/eligible months projected in each MEG by quarter. States who are phasing in managed care programs or populations may choose to have quarterly estimates that are not equal (i.e., P1 Q1 reflects a different enrollment than P1 Q4).

Step 3. Total the member/eligible months for each quarter and year. Calculate the annual and quarterly rate of increase/decrease in member months over the projected period. Explain the rate of increase/decrease in the State Completion section.

Appendix D2.S - Services in Waiver Cost

Document the services included in the waiver cost-effectiveness analysis.

Step 1. List each State Plan service and 1915(b)(3) service under the waiver and indicate whether or not the service is:

- State Plan approved;
- A 1915(b)(3) service;
- A service that is included in a capitation rate; paid to either MCOs, PIHPs, or PAHPs, (whichever is applicable);
- A service that is not a waiver service but is impacted by the MCOs, PIHPS, or PAHPs (whichever is applicable);
- a service that is included in the PCCM FFS reimbursement.

The chart in **Appendix D2.S** should be modified to reflect each State's actual waiver program. States should indicate which services are provided under each MEG, if the benefit package varies by MEG. Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

Step 2. Please note any proposed changes in services on Appendix D2.S with a *. *See the Nebraska example for illustration purposes.*

Step 3. List the State Plan Services included in the Actual Waiver costs (only State Plan Service costs may be included in an initial waiver's Actual Waiver Costs). Please also list the 1915(b)(3) non-State Plan services proposed in the initial waiver and any 1915(b)(3) services included in the Actual Waiver costs for a conversion or renewal waiver. For an MCO/PIHP/PAHP waiver, include services under the capitated rates, as well as services provided to managed care enrollees on a fee-for-service wraparound basis (note each). For a PCCM program, include services requiring a referral, as well as services provided to waiver enrollees on a wraparound basis. Please add lines and specify as needed.

(Column B Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column C Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column D Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column E Explanation) MCO Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO. If a 1915(b)(3) service in an MCO is capitated, please mark this column.

(Column F Explanation) Fee-for-Service Reimbursement impacted by MCO: Check this column if the service is not the responsibility of the MCO, but the MCO or its contracted providers can affect the utilization, referral or spending for that service. *For example, if the MCO is responsible for physician services but the State pays for*

pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription. Do not mark services NOT impacted by the MCO and not included in the cost-effectiveness analysis. *For example, a State would not include Optometrist screening exams in states where vision services are not capitated, a PCP referral is not required for payment, and PCP do not refer or affect patient access to vision screening examinations.*

(Column G Explanation) PCCM Fee-for-Service Reimbursement: Check this column if this service will be included in the waiver and will require a referral/prior authorization or if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the waiver. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

(Column H Explanation) PIHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PIHP. If a 1915(b)(3) service is capitated in a PIHP, please mark this column.

(Column I Explanation) Fee-for-Service Reimbursement impacted by PIHP: Check this column if the service is not the responsibility of the PIHP, but is impacted by it. For example, if the PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PIHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PIHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

(Column J Explanation) PAHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PAHP. If a 1915(b)(3) service is capitated in a PAHP, please mark this column. *Note: the Nebraska example did not include a PAHP and so did not include this column.*

(Column K Explanation) Fee-for-Service Reimbursement impacted by PAHP: Check this column if the service is not the responsibility of the PAHP, but is impacted by it. For example, if the PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PAHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PAHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance. Note: the Nebraska example does not include a PAHP delivery system and so did not include this column.*

Note: Columns C and D are mutually exclusive. Columns E and F are mutually exclusive for the MCO program. Columns H and I are mutually exclusive for the PIHP program.

Columns J and K are mutually exclusive for the PAHP program. Each service should have a mark in columns C or D. If the State has more than one MEG, Appendix D2 should reflect what services are included in each MEG.

Chart: Inclusion of Services in Cost-Effectiveness Test

Note: All references to the single CMS 64.9 Waiver form refer to a 1915(b) waiver that does not include any SCHIP Medicaid expansion populations. If a 1915(b) includes an SCHIP Medicaid expansion population, the State would also complete a CMS 64.21U Waiver form for the applicable SCHIP Medicaid expansion population. In addition, the State can always choose to divide its data into MEGs for additional reporting categories. Services included in other 1915(b) waivers should be excluded and not counted under two separate 1915(b) cost-effectiveness tests. Services in 1915(c) waivers should only be included for concurrent 1915(b)/1915(c) waivers. Services for 1115 Demonstration waivers should only be included if the 1915(b) population is being used as an impacted population in the 1115 Demonstration. *See the Technical Assistance Manual for additional information.*

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
Medicaid beneficiary is enrolled only in 1915(b) for transportation	PAHP	Transportation only	Transportation	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for dental	PAHP	Dental only	Dental	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for mental health – remaining services are FFS or under 1932 SPA *(examples: rural Nebraska and Iowa)*	PIHP	Mental Health and Substance Abuse are under waiver. Pharmacy, rehabilitation services, and inpatient psychiatric services for individuals under age 21 are fee-for-service.	All Mental Health, Substance Abuse, Pharmacy, Inpatient psychiatric services for individuals under age 21, and Rehabilitation services for waiver enrollees are reported on single *CMS-64.9 Waiver form* for the 1915(b) waiver.	All other Medicaid services
Medicaid beneficiary is enrolled in one 1915(b) waiver for	PIHP and MCO	All services	All services for waiver enrollees are reported on a single	None.

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
mental health and MCO services *(examples: urban Nebraska special needs children)*			*CMS-64.9 Waiver form*	
Medicaid beneficiary is enrolled in 1915(b) for mental health and separate 1915(b) for MCO	PIHP and MCO	All services except pharmacy are in one waiver or the other	The State divides all services for waiver enrollees into two *CMS-64.9 Waiver forms*: one for the mental health 1915(b) and the other for the MCO 1915(b).	None.
Medicaid beneficiary is enrolled in a single1915(b) for mental health and PCCM *(examples: urban Nebraska special needs children)*	PIHP and PCCM	All services except school-based services	All services including school-based services for waiver enrollees are reported on a *CMS-64.9 Waiver form*	None.
Medicaid beneficiary is enrolled in 1915(b) PCCM or MCO	PCCM and/or MCO	All services	All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form*	None.

Appendix D2.A Administrative Costs in the Waiver
Document the administrative costs included in the Actual Waiver Cost.

Step 1. Using *CMS-64.10 Waiver Form* line items numbers and titles, document the State's administrative costs in the waiver. **Do not include MCO/PIHP/PAHP/PCCM entity administration costs.** For initial waivers, this will include only fee-for-service costs such as MMIS and SURS costs. For renewal waivers and conversion waivers, the administrative costs will include managed care costs such as enrollment brokers, External Quality Review Organizations, and Independent Assessments. Add lines as necessary to distinguish between multiple contracts on a single line in the CMS-64.10. *Note: PCCM case management fees are not considered State Administrative costs because CMS matches those payments at the FMAP rate and states claim those costs on the CMS-64.9*

*Waiver form. Services claimed at the FMAP rate should be reported on **Appendix D2.S** and not reported on **Appendix D2.A**.*

Step 2. The State should allocate administrative costs between the Fee-for-service and managed care program depending upon the program structure. For example, for an MCO program, the State might allocate the administrative costs in the Administrative Cost Allocation Plan to the MCO program based upon the number of MCO enrollees as a percentage of total Medicaid enrollees. For a mental health carve out enrolling most Medicaid beneficiaries in the State, allocate costs based upon the mental health 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. Explain the cost allocation process in the preprint.

Appendix D3 – Actual Waiver Cost

Document Base Year and Retrospective Waiver Period expenditures (actual expenditures in the BY for initial/conversion waivers and R1 and R2 in renewal waivers). States that are eligible to use the expedited process for certain waivers need not complete Appendix D3; instead, attach the most recent waiver Schedule D. For all other submissions, States should complete **Appendix D3**.

The State must document the total expenditures for the services impacted by the waiver as noted in **Appendix D2.S**, not just for the services under the waiver. For an Initial Waiver or Conversion Waiver, the State must document the expenditures used in the BY PMPM. **All expenditures in the BY will be verified by the RO.** For a Renewal Waiver, the State must document the actual expenditures in the retrospective two-year period (R1 and R2) separating administration, 1915(b)(3), FFS incentives, capitated, and fee-for-service State Plan expenditures as noted. **Actual expenditures will be verified by the RO on a quarterly basis by comparing projections to actual expenditures and other routine audit functions.**

The actual expenditures used in the cost-effectiveness calculations should include all Medicaid program expenditures related to the population covered by the waiver, not just those services directly included in the waiver. If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64. Incentives to capitated entities are reflected in **Column D of Appendix D3** of the spreadsheets. Fee-for-service incentives, such as incentives to PCCM providers, are noted separately in **Column G of Appendix D3**. 1915(b)(3) services in the initial waiver will always be zero in **Column H of Appendix D3** of the initial waiver because 1915(b)(3) services are a result of savings under the waiver and cannot exist prior to the waiver.

Actual expenditures are based on the CMS-64 Waiver forms, which are based on date of payment not date of service.

States must separately document actual Medical Assistance service expenditures and actual State administrative costs related to those services. Actual case management fees paid to providers in a PCCM program should be included as service expenditures.

Since a State may be in the process of developing a Renewal Waiver during the second year of the waiver (R2) period (to avoid an extension), the State use only data from the Schedule D and document the number of months of data used on Appendix D7. Appendix D7 will recalculate the formulas based upon the amount of data available to the State. The State should not project any actual expenditures that are not yet available for R2.

Should a State request and be granted one or more 90-day temporary extension(s) for submitting a Renewal Waiver, the following process applies depending on the length of the extension:

- For three or fewer 90-day temporary extensions (a period of less than one year after the expiration of the waiver), the State must demonstrate cost-effectiveness over the original two-year period included in the waiver. In other words, if a waiver considered years CY 2003 and CY 2004 as P1 and P2, respectively, and 2 three-month temporary extensions were obtained, the State would still be required to demonstrate cost-effectiveness for calendar year 2003 and 2004 by comparing actual expenditures (R1 and R2) to the projected expenditures (P1 and P2) for these two years in aggregate. In this scenario, actual expenditures for the entire R2 period may be available to support the Renewal Waiver calculations.
- For four or more temporary extensions (a period of one year or more after the expiration of the waiver), the State must demonstrate cost-effectiveness for the original two-year period included in the waiver as previously described and in addition demonstrate cost-effectiveness for the one-year extension period (to the extent data is available – in this case CY2005). In this scenario, actual expenditures for the entire R2 period will be available to support the Renewal Waiver calculations, but the extension year may require projecting actual expenditures. The State's extension year will be compared to the expenditure projections as if P2 were 24 months rather than 12 months.

Number of Extensions	Demonstration of Cost-Effectiveness	Example
3 or fewer 90-day temporary extensions	Demonstrate cost-effectiveness for the original two-year period	Waiver CY2003 and CY2004 2 Extensions through 7/1/2005 State CE covers only CY2003 and CY2004
4 or more temporary 90-day extensions	Demonstrate cost-effectiveness for the original two-year period and for each additional one-year extension period	Waiver CY2003 and CY2004 4 Extensions through CY2005 State CE covers CY2003, CY2004, and CY2005

Fee-for-service Institutional UPL Expenditures to include and not include in the cost-effectiveness analyses.

- **Transition amounts should be excluded** from the Cost-Effectiveness test. A transition amount is what the State spent over 100% of the institutional fee-for-service UPL (i.e., the "excess"). The State should isolate the excess amounts to remain in fee-for-service outside of the waiver and include only the amount under 100% of the FFS UPL in the Cost-effectiveness analysis.
- **Supplemental payments at or below 100% of the UPL should be included** in the cost-effectiveness analysis. States that are not transition States may in fact make supplemental payments below or up to the 100% UPL and that money should be included in the cost-effectiveness. The entire amount of the supplemental payment at or below the UPL should be in the 1915(b) analysis.

States should contact their RO for additional State-specific guidance on the inclusion and exclusion of Fee-for-service Institutional UPL payments.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.** The renewal will list the MEGS twice – once for R1 and once for R2. *See the example spreadsheets.*

Step 2. List the BY eligible member months (R1 and R2 member months, if a renewal). *See the example spreadsheets.*

Step 3. List the base year (R1 and R2 if a renewal) aggregate costs by MEG. Actual cost and eligibility data are required for BY (R1 and R2) PMPM computations. Aggregate Capitated Costs are in Column D. Aggregate FFS costs are in Column E. Add D+E to obtain the State Plan total aggregate costs in Column F. List FFS incentives in Column G. In a renewal or conversion waiver, list 1915(b)(3) aggregate costs in Column H. List Administrative costs in Column I. For an initial waiver, these PMPM costs are derived from the State's MMIS database or as noted from the explanation in the State Completion section under **Section D.I.H.a** Comprehensive Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D and with additional ad hoc reporting for 1915(b)(3) services and FFS incentive payments. The State must track FFS incentive and 1915(b)(3) payments separately (those costs will not be separately identified on Schedule D). The State must document that State Plan service aggregate costs amounts were reduced by the amount of FFS incentives and 1915(b)(3) costs spent by the State. To calculate the PMPM by MEG for 1915(b)(3) services, the State should divide the cost of 1915(b)(3) service costs by MEG for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for FFS incentives, the State should divide the cost of FFS incentives for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for State Plan Services, the State should divide the cost of State Plan Services from Schedule D (minus FFS incentives and 1915(b)(3) service costs) for R2 and divide by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit

the Schedule D used to calculate the PMPM amounts. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted.*

Step 4. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.

Step 5. The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training conducted by CMS in April 2003 and States should pay particular attention to this detail.***

Step 6. Total the base year capitated costs and fee-for-service costs to derive the total base year costs for services. Add all costs (F, G, H, and I) to obtain total waiver aggregate costs.

Step 7. Divide the base year (BY) costs by the annual BY (divide the R1 costs by the R1 MM or the R2 costs by the R2 MM, if a renewal) member months (MM) to get PMPM base year (R1 or R2) costs**.** In this instance, the State calculates the overall PMPM for BY (the overall PMPM for R1 or the overall PMPM for R2 in a renewal). The State will divide the costs of the program by the caseload for the same year from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each year of the waiver (R1 and R2). In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

Initial/Conversion	Renewal R1	Renewal R2
BY Costs BY MM	R1 Costs R1 MM	R2 Costs R2 MM
Overall PMPM for BY	Overall PMPM for R1	Overall PMPM for R2

Appendix D4 – Adjustments in the Projection

Document adjustments made to the BY or R1 and R2 to calculate the P1 and P2. The State will mark the adjustments made and document where in Appendix D5 the adjustment can be found. All adjustments are then explained in the State Completion portion of the Preprint.

Waiver Cost Projection Adjustments: On **Appendix D4**, check all adjustments that the State applied to the R1/R2 or BY data. In Column D, note the location of each adjustment in **Appendix D5**. Note: only the adjustments listed may be made. If the State has made another adjustment, the State should obtain CMS approval prior to its use. Complete the attached preprint explanation pages and include attachments as requested. ***Note:*** *(Initial Waiver only) Adjustments Unique to the Combined Capitated and PCCM*

Cost-effectiveness Calculations -- some adjustments to the Waiver Cost Projection in an initial waiver must be made due to a policy decision in the capitated program. Those adjustments are permitted only to the capitated programs and need an offsetting adjustment to the PCCM Waiver Cost Projections in order to make the PCCM costs comparable to the Actual Waiver Costs. Please see the State Completion Section of the initial waiver for further instructions if the State has a combined capitated and PCCM cost-effectiveness analysis.

Appendix D5 – Waiver Cost Projection

Each time a waiver is renewed, a State must develop a two-year projection of expenditures. States must calculate projected waiver expenditures (P1 and P2) for the upcoming period. Projected waiver expenditures for P1 and P2 should be created using the State's actual historical expenditures (e.g., BY data for an Initial or Conversion Waiver, or R2 data using R1 & R2 experience to develop trends for a Renewal Waiver) for the population covered under the waiver and adjusted for changes in trend (including utilization and cost increases) and other adjustments acceptable to CMS. For example, in an Initial or Conversion Waiver, a State should use its actual BY data to project its P1 and P2 expenditures. In a Renewal Waiver, a State should use its actual experience in R1 and R2 to project trends for its P1 and P2 expenditures from the endpoint of the previous waiver of R2. As a result, in each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2.

Projected waiver expenditures must include all Medicaid expenditures for the population included in the waiver, not just those services directly included in the waiver, calculated on a PMPM basis and including administrative expenses. (For example, a State must include services that are outside of the capitated or PCCM program.) If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64.

In projecting expenditures for the population covered by the waiver, States must use trends that are reflective of the regulation requirements for capitated rates and fee-for-service history for fee-for-service rates. The State must document and explain the creation of its trends in the State Completion Section of the Preprint. CMS recommends that a State use at least three years of Medicaid historical data to develop trends. States must use the State historical trends for the time periods where actual State experience is available. States must use the prescribed methods (see the State Completion Section) for inflating FFS incentives (no greater than the State Plan trend rate), 1915(b)(3) services (the lower of State Plan service and actual 1915(b)(3) trend rates), and administration (historic Medicaid administration trend rates unless the State is using sole source procurement to procure State Plan services)

States need to make adjustments to the historical data (BY for initial/conversion and R2 for renewals) used in projecting the future P1 and P2 PMPMs to reflect prospective periods. For Renewals, these adjustments represent the impact on the cost of the State's Medicaid program from such things as: State Plan service trend, State Plan programmatic/policy/pricing changes, administrative cost adjustments, 1915(b)(3) service trends, incentives (not in the capitated payment) adjustments, and other. Since States are required to consider the effect of all Medicaid costs for the waiver population, States should consider adjustments that might impact costs for services not directly covered under the waiver (i.e., global changes to the Medicaid program).

1915(b)(3) services must be paid out of savings in the future years (P1 and P2) of the waiver. Under 1915(b)(3) authority, states can offer additional benefits using savings from providing State Plan services more efficiently. The following principles and requirements will be used to evaluate the cost-effectiveness of waiver requests that include 1915(b)(3) services. The principles are intended to highlight concepts and policy goals (i.e., **what** the policy guidance is intended to accomplish). The requirements are intended to outline operational details (i.e., **how** the policy goals will be pursued).

2) Aggregate spending

- *General principle*—Under a 1915(b) waiver, combined spending on State Plan and 1915(b)(3) services cannot exceed what would have occurred without the waiver. In other words, States cannot spend more on 1915(b)(3) services than they save on State Plan services under the waiver.
- ➢ *Requirement*—Combined spending on State Plan and 1915(b)(3) services cannot exceed projected spending during any given waiver period.

3) Base-year spending (R2 for renewals) (for waiver projections)

- *General principle one*—Spending for 1915(b)(3) services should not exceed the cost of providing these services.
- *General principle two*—Spending for 1915(b)(3) services should not exceed the "budget" for these services, as determined in a state's waiver application.
- ➢ *Requirement (for initial waiver applications)*—The base year amount for 1915(b)(3) services under a new waiver application is limited to the lower of:
  a. Expected costs for the 1915(b)(3) services or
  b. Projected savings on State Plan services
- ➢ *Requirement (for Renewals and Conversion Renewals)*—The base year (R2 for renewals) amount for projecting spending on 1915(b)(3) services under a waiver renewal is limited to the lower of:
  a. Actual costs for 1915(b)(3) services under the current waiver or
  b. Projected costs for 1915(b)(3) services under the current waiver (P2 in the previous submittal)

4) Growth in spending (price increases and use of services, but not changes in enrollment)

- *General principle one*—Growth in spending on 1915(b)(3) services cannot exceed growth in spending for State Plan services under the waiver. (This ensures that savings on State Plan services for both initial waiver and renewal periods finance spending for 1915(b)(3) services.)
- *General principle two*—Growth in spending on 1915(b)(3) services cannot exceed historical growth in spending for these services. (This ensures that growth in spending on waiver services is reasonable for the particular services.)

➢ *Requirement*—Growth in spending for 1915(b)(3) services is limited to the lower of:

a. The overall rate of trend for State Plan services, or
b. State historical trend for 1915(b)(3) services

5) Covered services

- *General principle*—If the State wants to expand 1915(b)(3) services, the State must realize additional savings on State Plan services to pay for the new services.

➢ *Requirement*—Before increasing its budget for 1915(b)(3) waiver services, the State must submit an application to CMS to modify its waiver (or document the modification in its renewal submittal). This application must show both:

a. How additional savings on State Plan services will be realized, and
b. That the savings will be sufficient to finance expanded services under the waiver

- *Special case*—A State also could be required to cut back (b)(3) services because of increased use of State Plan services.

5) Payments

- *Requirement*—As a condition of the waiver, capitated 1915(b)(3) payments must be calculated in an actuarially sound manner.

States must calculate a separate capitation payment for 1915(b)(3) services using actuarial principles and the same guiding principles as the regulation at 42 CFR 438.6(c) -with the exceptions that the 1915(b)(3) rates are based solely on 1915(b)(3) services approved by CMS in the waiver and the administration of those services. The actual payment of the 1915(b)(3) capitated payment can be simultaneous with the payment of the State Plan capitated payment and appear as a single capitation payment. However, the State must be able to track and account for 1915(b)(3) expenditures separately from State Plan services.

1915(b)(3) services versus 42 CFR 438.6(e) services. Under a 1915(b) waiver, 1915(b)(3) services are services mandated by the State and paid for out of State waiver savings. 42 CFR 438.6(e) services are services provided voluntarily by a capitated entity out of its capitated savings. A State cannot mandate the provision of 42 CFR 438.6(e) services. In order to provide a service to its Medicaid beneficiaries, the State must have authority under its State Plan or through a waiver such as the 1915(b)(3) waiver. 1915(c)

and 1115 Demonstration waivers also have authority for the provision of services outside of the Medicaid State Plan. CMS will match managed care expenditures for services under the State Plan or approved through an approved waiver. The State cannot mandate the provision of services outside of its State Plan or a waiver.

Initial waivers must estimate the amount of savings from fee-for-service that will be expended upon 1915(b)(3) services in the initial waiver. The State must document that the savings in state plan services, such as reductions of utilization in hospital and physician services, are enough to pay for the projected 1915(b)(3) services. If the State contends that there is additional state plan savings generated from the 1915(b)(3) services those can only be documented after the State has documented that state plan-generated savings are enough to pay for the 1915(b)(3) Costs. Trend for 1915(b)(3) services in the initial waiver can be no greater than State Plan service trend (because there is no historic 1915(b)(3) service trend rate) as noted in the adjustments section.

The State must separately document Medical Assistance service expenditures and State administrative costs related to those services. Case management fees paid to providers in a PCCM program should be included as Medical Assistance service expenditures.

A State may make changes to their Medicaid and/or Medicaid waiver programs (e.g., changes to covered services or eligibility groups) during the period of time covered by an existing waiver. When the State makes these changes and there is a cost impact, CMS will require States to submit amendments which will modify P1 and P2 of the existing waiver calculations. By amending the existing P1 and P2 the State will ensure that when the State does its subsequent Renewal Waiver the R1 and R2 actual expenditures do not exceed the previous waiver's P1 and P2 expenditures solely as a result of the change to the Medicaid and/or Medicaid waiver program.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY eligible member months (R2 if a renewal). *See the example spreadsheets.*

Step 3. List the weighted average PMPM calculated in **Appendix D3** for Initial, Conversion or Comprehensive Renewal waivers.

Expedited Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D. To calculate the PMPM by MEG, the State should divide the cost from Schedule D for R2 and by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts.

Step 4. In **Appendix D5**, list the program adjustments percentages and the monetary size of the adjustment by MEG as applicable for State Plan services. The State may then

combine all adjustment factors which affect a given MEG, and apply the adjustments accordingly. The derivation of a combined adjustment factor must be explained and documented.

Note adjustments in different formats as necessary. *See the Nebraska example spreadsheet as an example only. Some adjustments may be additive and others may be multiplicative. Please use the appropriate formula for the State's method.*

Step 5. Compute the PMPM projection by MEG by adding the service, incentive, administration, and 1915(b)(3) costs and the effect of all adjustments. These amounts need to be reflected in the State's next waiver renewal. These amounts represent the final PMPM amounts that will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes among MEGs when submitting their next waiver renewal cost-effectiveness calculations. In the subsequent renewal, the State should have PMPM Actual Waiver costs for each MEG for the 2-year period equal to or less than these Projected PMPM Waiver Costs for each MEG.

Appendix D6 – RO Targets

For the purpose of on-going quarterly monitoring in the future period, the State must document total cost and PMPM cost projections for RO use. The ROs will be using a two-fold test: one that monitors for overall growth in waiver costs on the CMS-64 forms and another that monitors for PMPM waiver cost-effectiveness. The State projections for RO use in both tests are in Appendix D6.

The first test projects quarterly aggregate expenditures by MEG for RO use in monitoring CMS 64.9 Waiver, CMS 64.21U Waiver, and CMS 64.10 Waiver expenditures during the upcoming waiver period. On a quarterly basis, CMS will compare aggregate expenditures reported by the State on CMS-64 Waiver forms to the State's projected expenditures (P1 and P2) included in the State's cost-effectiveness calculations as a part of the quarterly CMS-64 certification process. As part of the waiver submission, the State must calculate and document the projected quarterly aggregate Medical Assistance services and State administrative expenditures for the upcoming period. This projection is for the population covered under the waiver and will assist RO financial staff in monitoring the total waiver spending on an on-going basis.

The second test projects quarterly PMPM expenditures by MEG for RO use in monitoring waiver cost-effectiveness in the future waiver period. Because states are required to demonstrate cost-effectiveness in the historical two-year period of each Renewal Waiver, CMS intends to monitor State expenditures on an ongoing basis using the State's CMS-64 Waiver submissions. CMS will determine if the State's quarterly CMS-64 Waiver submissions support the State's ability to demonstrate cost-effectiveness when the State performs its Renewal Waiver calculations. For the second test, States are not held accountable for caseload increases. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected expenditures, CMS will work with the State to determine the reasons and to take potential

corrective actions. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State must submit member month data corresponding to the quarterly submission of the CMS-64 on an on-going basis. The State should ensure that the member month data submitted on an on-going basis is comparable to the member month data used to prepare the P1 and P2 member month projections. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months**.

Step 2. List the P1 and P2 projected member months by quarter for the future period.

Step 3. List the P1 and P2 MEG PMPM cost projections from **Appendix D5**. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State will calculate the weighted average PMPM with Casemix for P1 and P2 (respectively).

Renewal P1	Renewal P2
$\frac{\text{P1 PMPM Costs x P1 MM}}{\text{P1 MM}}$	$\frac{\text{P2 PMPM Costs x P2 MM}}{\text{P2 MM}}$
Casemix for P1	Casemix for P2

The State is calculating the PMPM with Casemix for P1 and P2 so that the Region can compare the projected PMPMs to the actual PMPMs for administration (the State is calculating all of the PMPMs but only the administration PMPM will be used in Appendix D6). Administration is an area of risk for States in a 1915(b) waiver. If a State does not enroll enough persons into the program to offset high fixed administration costs, the State is at risk for not being cost-effective over the two year period. The Region will use this particular weighted PMPM to monitor State enrollment levels to ensure that high administrative costs are more than offset on an on-going basis.

Step 4. Multiply the quarterly member month projections by the P1 and P2 PMPM projections to obtain quarterly waiver aggregate targets for the waiver. *See the example spreadsheets.*

For the first aggregate spending test, the State will use the MEG PMPM from Appendix D5 multiplied by the projected member months to obtain the aggregate spending. The MEG PMPM from Appendix D5 is the number that States will be held accountable to in their waiver renewal. However, States will not be held accountable to the projected member months in their waiver renewal. For this reason, a second test modifying the demographics to reflect actual caseload is necessary.

			Q1 Quarterly Projected Costs

Medicaid Eligibility Group (MEG)	Total PMPM Admini-stration Cost Projection	Total PMPM Projected Service Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Admini-stration Costs
MCHIP - MCO/PCCM/ PIHP (3 co.)	$ 10.00	$ 192.90	81	$ 15,624.75	$ 810.39
MCHIP - PIHP statewide	$ 0.86	$ 21.20	28,821	$ 611,004.39	$ 24,866.56
Title XIX MCO/PCCM/ PIHP (3 co)	$ 47.33	$ 954.89	15,981	$ 15,260,090.40	$ 756,396.07
Title XIX - PIHP statewide	$ 2.37	$ 48.20	444,217	$ 21,409,496.79	$ 1,051,238.55
Total			**489,100**	**$ 37,296,216.33**	**$ 1,833,311.56**
Weighted Average PMPM Casemix for P1 (P1 MMs)	**$ 3.77**				

Step 5. Create a separate page that documents by quarter Form 64.9 Waiver, Form 64.21U Waiver, and Form 64.10 Waiver costs separately for ease of RO CMS-64 monitoring. *See the example spreadsheets.*

Example:

Projected Year 1 - July 1, 2002 - June 30, 2003

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Start 7/1/2002
64.21U Waiver Form	MCHIP - MCO/PCCM/PIHP (3 co)	$ 15,624.75
64.21U Waiver Form	MCHIP - PIHP statewide	$ 611,004.39
64.9 Waiver Form	Title XIX - MCO/PCCM/PIHP (3 co)	$ 15,260,090.40
64.9 Waiver Form	Title XIX - PIHP statewide	$ 21,409,496.79
64.10 Waiver Form	All MEGS	$ 1,833,311.56

Step 6. Create a separate page that documents by quarter PMPM MEG costs separately for each of RO monitoring. Please include space for RO staff to list actual member months and aggregate totals by quarter. Please include formulas for RO staff to calculate actual PMPMs by quarter for comparison to projections. *See the example spreadsheets.*

For the second test, the State will carry forward the P1 (and P2 respectively) MEG PMPM services costs and the weighted average PMPM administration costs Casemix for P1 (and P2 respectively).

Divide the actual aggregate costs by the actual aggregate member months (MM) to get PMPM actual costs**.** The State will divide the costs of the program by the caseload for the same quarter from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each quarter of the waiver. In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

On-going Actual P1 Q1	On-going Actual P2 Q5
P1 Q1 Actual Costs P1 Q1 Actual MM	P2 Q5 Actual Costs P2 Q5 Actual MM
Casemix for P1 Q1 actual	Casemix for P2 Q5 actual

On an on-going basis, the State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms. The RO analyst will enter the member month and CMS-64 form totals into the worksheet, which will calculate the actual MEG PMPM costs. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected PMPM expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions.

Example

Waiver Form	**Medicaid Eligibility Group (MEG)**	**State Completion Section - For Waiver Submission**	**RO Completion Section - For ongoing monitoring**		
			Q1 Quarterly Actual Costs		
		P1 Projected PMPM From Column I (services) From Column G (Administration)	**Member Months Actuals Start 7/1/2002**	**Actual Aggregate Waiver Form Costs**	**Actual PMPM Costs**

64.21U Waiver Form	MCHIP - MCO/PCCM /PIHP (3 co.)	**$ 192.90**			#DIV/0!
64.21U Waiver Form	MCHIP - PIHP statewide	**$ 21.20**			#DIV/0!
64.9 Waiver Form	Title XIX - MCO/PCCM /PIHP (3 co)	**$ 954.89**			#DIV/0!
64.9 Waiver Form	Title XIX - PIHP statewide	**$ 48.20**			#DIV/0!
64.10 Waiver Form	All MEGS	**$ 3.77**			#DIV/0!

Appendix D7 - Summary

Document the State's overall cost-effectiveness analysis by waiver year.

In a renewal analysis, the State must clearly demonstrate that the PMPM actual waiver expenditures did not exceed the projected PMPM waiver expenditures for the population covered by the waiver. *For example, suppose a State's Initial Waiver (ST 01) considered years 2003 and 2004 to be P1 and P2 respectively. In the subsequent Renewal Waiver (ST 01.R01), the State's R1 and R2 will also be years 2003 and 2004, respectively. The State must demonstrate that in total the actual expenditures in the current Renewal Waiver's R1 and R2 (2003 and 2004) did not exceed the total projected expenditures in the Initial Waiver's P1 and P2 (2003 and 2004). Taking the example above, a State would use the actual expenditures from 2003 and 2004 as the basis for projecting expenditures for the renewal waiver period 2005-2006 (P1 and P2 respectively). In the second Renewal Waiver (ST 01.R02), the actual expenditures in the renewal period for 2005-2006 (R1 and R2) must be less than the expenditures for 2005-2006 (P1 and P2) projected in the previous renewal (ST 01.R01). For each subsequent renewal, the State will compare actual expenditures in R1 and R2 to the projected P1 and P2 values from the previously submitted Renewal Waiver.*

Cost-effectiveness will be determined based on the sum of Medical Assistance service expenditures and State administrative costs on a PMPM for the two-year period. In this instance, the weighted PMPM for both the projection and the actual cost is based on the Casemix for actual enrollment in R1 and R2. In this way, the State is not held accountable for any caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY (R1 and R2 if a renewal), P1 and P2 annual projected member months.

Step 3. List the BY (R1 and R2 if a renewal), P1 and P2 PMPM projections from **Appendix D5**.

List and calculate the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the PMPM for that year's demographics and for the previous year's demographics so that CMS can compare the PMPM for the enrolled caseload to the PMPM holding the caseload's demographics constant. In short, the new PMPM times the old MM (new dollars times old weights = Casemix effect for old MM) is the Casemix for the old MM.

Initial or Conversion Waiver

Year	Calculation	Where Already Calculated	Formula
BY	BY Overall PMPM for BY (BY MMs)	Appendix D3	$\frac{\text{BY Aggregate Costs}}{\text{BY MM}}$
P1	P1 Weighted Average PMPM Casemix for BY (BY MMs) P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	Appendix D6	$\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs) P2 Weighted Average PMPM Casemix for BY (BY MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6 Appendix D6	$\frac{\text{P2 PMPM x P1 MM}}{\text{P1 MM}}$ $\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$ $\frac{\text{P2 PMPM x BY MM}}{\text{BY MM}}$ $\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$

Renewal Waiver

Year	Calculation	Where Already Calculated	Formula
R1	R1 Overall PMPM for R1 (R1 MMs)	Appendix D3	$\frac{\text{R1 Aggregate Costs}}{\text{R1 MM}}$
R2	R2 Weighted Average PMPM Casemix for R1 (R1 MMs) R2 Overall PMPM for R2 (R2 MMs)	Appendix D3	$\frac{\text{R2 PMPM x R1 MM}}{\text{R1 MM}}$ $\frac{\text{R2 Aggregate Costs}}{\text{R2 MM}}$
P1	P1 Weighted Average PMPM Casemix for R2 (R2 MMs) P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	Appendix D6	$\frac{\text{P1 PMPM x R2 MM}}{\text{R2 MM}}$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		$\frac{\text{P2 PMPM x P1 MM}}{\text{P1 MM}}$

	P2 Weighted Average PMPM Casemix for P2 (P2 MMs) P2 Weighted Average PMPM Casemix for R1 (R1 MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6 Appendix D6	$\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$ $\frac{\text{P2 PMPM x R1 MM}}{\text{R1 MM}}$ $\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$

Step 4. Calculate a total cost per waiver year. Multiply BY MM by BY PMPM. (Renewal Waiver, multiply R1 MM by R1 PMPM and multiply R2 MM by R2 PMPM) Multiply P1 MM by P1 PMPM. Multiply P2 MM by P2 PMPM. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

Step 5. Renewal Waiver only - Calculate the Total Previous Waiver Period Expenditures (Casemix for R1 and R2). *Note: the Total Cost per Waiver for R1 should match the Schedule D submitted. No portion of R2 should be projected in order to timely submit the waiver renewal application.* Instead, the State should use data from the Schedule D and complete the number of months of data used in Appendix D7.

Step 6. Calculate the Total Projected Waiver Expenditures for P1 and P2.

Step 7. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.
The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training and States should pay particular attention to this detail.***

On Appendix D7, the State will need to enter the number of months of data in each BY (for an initial and conversion waiver) and R1 and R2 (for a renewal waiver). The State will also need to enter the number of months it is projecting in P1 and P2 (typically 12 months in both P1 and P2). If there is a gap of time between the BY/R2 and P1 and P2, the State will also need to enter the number of months in the "gap".

Example 1: Renewal with less than 2 years of data in R2
R1 - State Fiscal Year 2001 (July 1, 2000 to June 30, 2001)
R2 - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2003 (July 1, 2002 to June 30, 2003)
P2 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)

The State wants to submit its renewal on May 1, 2002, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2002. The State then has less than two full years of R1 & R2, in this instance 12 months of R1 but only 9 months of R2:

1. The State enters the number of months for R1, R2, P1, and P2 in the spreadsheet in Appendix D7.

NUMBER OF MONTHS OF DATA		
	R1	12
	R2	9
	Gap (end of R2 to P1)	3
	P1	12
	P2	12
	TOTAL	48
	(Months-12)	36

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

Overall R1 to P2 Change (monthly)	Overall R1 to P2 Change (annualized)
0.4%	**5.5%**
0.5%	**5.6%**
0.5%	**5.6%**
0.5%	**6.5%**
0.5%	**6.1%**
0.6%	**7.4%**

Example 2: Conversion with a lag between BY and P1
BY - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)
P2 - State Fiscal Year 2005 (July 1, 2004 to June 30, 2005)

The State wants to submit its renewal on May 1, 2003, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2003. The State then has a full year of BY but a lag between BY and P1 of 12 months:

1. The State enters the number of months for BY, gap, P1, and P2 in the spreadsheet in Appendix D7.

NUMBER OF MONTHS OF DATA	
BY	12
Gap (end of BY to P1)	12
P1	12
P2	12
TOTAL	48
(Months-12)	36

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

Overall BY to P2 Change (monthly)	Overall BY to P2 Change (annualized)
0.7%	**8.8%**
0.6%	**6.9%**
0.7%	**8.6%**
0.8%	**10.1%**
0.8%	**9.4%**
0.9%	**11.5%**

Step 7. Calculate the annual percentage change. For Initial and Conversion waivers, calculate the percentage change from BY to P1, P1 to P2 and BY to P2 for each MEG. For renewals, calculate the percentage change from R1 to R2, R2 to P1, P1 to P2, and R1 to P2 for each MEG. Calculate the annual percentage change for the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the annual percentage change in the PMPM compared to the previous year for that year's demographics and for the previous year's demographics. This allows CMS to compare the percentage of the PMPM that changed due to the caseload's demographics changes. The sample spreadsheets have appropriate formulas for State use. Explain these percentage changes in the State Completion section.

Step 8. Renewal Waiver only - list the PMPM cost projections (P1 and P2) by MEG from the previous waiver submittal.

Step 9. Renewal Waiver only - Calculate the Actual Previous Waiver Period Expenditures, Total Projection of Previous Waiver Period Expenditures, and Total Difference between Projections and Actual Waiver Cost for the Previous Waiver using actual R1 and R2 member months. Using actual R1 and R2 member months will hold the State harmless for caseload changes. Multiply the PMPM projections by the actual R1 and R2 member months to obtain the overall expenditures for the past Waiver Period.

Subtract waiver actual waiver costs for R1 and R2 from the projected PMPM program costs previously submitted (P1 and P2 in the previous waiver submission) to obtain the difference between the Projections and Actual Waiver Cost for the retrospective period. If **Actual Waiver Service Cost plus the Actual Waiver Administration Cost is less than or equal to Projected Waiver Cost,** then the State has met the Cost-effectiveness test and the waiver may be renewed.