

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

**The Enhanced Prenatal and Postpartum  
Home Visitation Pilot Project and Managed Care Program**

**South Carolina  
Department of Health and Human Services**

**December 10, 2015**

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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 South Carolina** requests a waiver under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is the **Enhanced Prenatal and Postpartum Home Visitation Pilot Project (“HV Pilot Project”) and Managed Care Program.**

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

- initial request for new waiver.** All sections are filled.
- amendment request for existing waiver, which modifies Section/Part \_\_\_\_
  - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
  - Document is replaced in full, with changes highlighted
- renewal request
  - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
  - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
    - Section A is  replaced in full
    - carried over from previous waiver period. The State:
      - assures there are no changes in the Program Description from the previous waiver period.
      - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
  - Section B is  replaced in full
  - carried over from previous waiver period. The State:
    - assures there are no changes in the Monitoring Plan from the previous waiver period.
    - assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

**Effective Dates:**

This waiver is requested for a period of **5 years**; effective **January 1, 2016** and ending **December 31, 2020**.

**This waiver may be considered for a five year waiver period because it meets the requirements of Section 2601 of the Affordable Care Act as outlined in SMDL #10-022 dated November 9, 2010. This waiver seeks to provide enhanced prenatal, postpartum, and infant home visit services that are not otherwise available under the State Plan. These services would be available to dually eligible beneficiaries under the waiver qualifying for the HV Pilot Project.**

**State Contact:**

The State contact person for this waiver is **Megan Old** and can be reached by telephone at **(803) 898-0080** or e-mail at **Megan.old@scdhhs.gov**.

## 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.*

**The South Carolina Department of Health and Human Services (SCDHHS) seeks advice on a regular, ongoing basis from the federally recognized tribes in South Carolina on matters related to Medicaid. In accordance with the tribal notice requirements established in South Carolina's State Plan, the Medical Care Advisory Committee (MCAC), which includes both tribal representatives and other community stakeholders, meets on a quarterly basis to discuss proposed Medicaid policy changes, including all State Plan Amendments (SPAs), waiver proposals, extensions, amendments and renewals. The MCAC met on May 5, 2015 to discuss this waiver. Prior to the meeting, all MCAC committee members received a written advisement summarizing this 1915(b) waiver proposal.**

**In addition to the formal MCAC meetings, the SCDHHS also consults directly with the federally-recognized tribes in South Carolina through monthly meetings via video conference and calls. Tribal attendees include representatives from the Catawba Service Unit, including Indian Health Service staff and the Chief of the Catawba Indian Nation. This 1915(b) waiver proposal was discussed at the monthly meeting occurring on April 29, 2015. The tribal representatives on the call did not express concerns or suggest revisions to the proposed 1915(b) waiver project.**

**In October 2015, the State revised its initial 1915(b) waiver proposal to include a managed care component. In accordance with the tribal notice requirements, the State will update the MCAC members of the waiver revision at its next meeting scheduled for November 17, 2015. The State will apprise CMS of any comments received on this waiver proposal at the MCAC meeting.**

#### 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).*

**The South Carolina Department of Health and Human Services (SCDHHS) has continually sought to develop a health care delivery model founded upon the establishment of medical homes for Medicaid beneficiaries, with the ultimate goal of improving the quality of care. In 1996, SCDHHS implemented its first managed care initiative through an HMO program, and later expanded the overall managed care initiative to include a primary care case management component (PCCM). The**

**State currently operates a statewide comprehensive managed care program through 1932(a) state plan authority that covers individuals eligible for enrollment in a risk-based managed care organization. SCDHHS currently contracts with six managed care organizations (MCOs) to provide healthcare services to beneficiaries through a network of healthcare professionals, including both primary and specialty care, as well as hospitals, pharmacies, and other providers. The MCOs create a medical home for beneficiaries by:**

- **Providing accessible, comprehensive, family-centered coordinated care;**
- **Managing the beneficiary’s health care, performing primary and preventive care services, and arranging for any additional needed care;**
- **Providing beneficiaries access to a “live voice” 24 hours a day, 7 days a week, to ensure access to appropriate care; and**
- **Providing beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room.**

**As part of the State’s overall initiative to create increased services and supports to at-risk pregnant women and families under the HV Pilot Project, SCDHHS seeks to transition a portion of the existing managed care population to managed care authority under this 1915(b) waiver. Specifically, the population targeted for transition to managed care under this waiver authority are individuals enrolled in an MCO that are most likely to be eligible for the HV Pilot Project (women of childbearing age and children less than two years of age). Please refer to the detailed description of the subset of the State’s current managed care population to be transitioned to this new authority on page 17 of this waiver application.**

## A. Statutory Authority

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

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

**Application: Managed Care Initiative Only**

- 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.

**Application: HV Pilot Project Only**

- 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)

## **HV PILOT PROJECT:**

**The South Carolina Department of Health and Human Services (SCDHHS) Enhanced Prenatal and Postpartum Home Visitation Pilot Project (HV Pilot Project) will enable South Carolina to pilot and evaluate an enhancement to the current postpartum home visitation services offered to Medicaid beneficiaries under the State Plan.**

**In an effort to improve maternal and infant health outcomes, the HV Pilot Project will test the provision of enhanced home visit services through the adoption of the Nurse-Family Partnership (NFP) Program model. The NFP model offers a comprehensive, evidence-based prenatal and postpartum home visitation program that utilizes trained registered nurses to provide one-on-one home visits with first time, low-income mothers. The goals of the HV Pilot Project are to improve health outcomes and decrease total Medicaid expenditures among families who receive the enhanced NFP home visit services through participation in the HV Pilot Project. Ultimately, the provision of the enhanced home visit services is not only expected to generate Medicaid savings through improved birth outcomes, but the pilot is also expected to create long term social and economic benefits resulting from increased birth spacing and improved health outcomes for mother and child.**

**Under the 1915(b) authority, the SCDHHS intends to expand home visit services and waive the freedom of choice of providers for HV Pilot Project beneficiaries by requiring all participating providers to be affiliated with the Nurse-Family Partnership National Service Office and to provide home visit services in accordance with the NFP evidence-based service delivery model. The HV Pilot Project will evaluate the impact of the NFP evidence-based home visitation program when delivered as a Medicaid intervention targeted to at-risk beneficiaries.**

**While this 1915(b) waiver seeks to enroll several categories of Medicaid enrolled women and their children under two years of age into managed care (see description on page 17 for specific populations included in the waiver), the HV Pilot Project component of the waiver will specifically target first time pregnant mothers and other at-risk pregnant beneficiaries for the additional 1915(b)(3) services. Since the program is being implemented on a pilot basis, enrollment will be limited to an average of eight hundred (800) new pregnant participants each year of the waiver for the first four (4) years (see Appendix D for yearly enrollment maximums). Once the newborn children of participating mothers are born, the children will be automatically enrolled in the HV Pilot Project and will become eligible to receive the enhanced home visit services provided under this waiver as well. Over the course of the five (5) year waiver, the HV Pilot Project will provide the enhanced NFP home visitation services to a total of approximately six thousand four hundred (6,400) low-income Medicaid beneficiaries,**



**comprised of approximately three thousand two hundred (3,200) women and three thousand two hundred (3,200) children.**

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.

**Application: HV Pilot Project Only**

- 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.

**Application: Managed Care Initiative and HV Pilot Project**

- 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.

**Application: Managed Care Initiative and HV Pilot Project**

- 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.

**Application: Managed Care Initiative Only**

- 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. X **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

X is different than stipulated in the state plan (please describe)

**HV PILOT PROJECT:**

**The State Plan currently provides for postpartum home visits at a rate of \$96.64 per home visit. However, due to the significant enhancements, additional services and expanded scope of the home visits to both the mother and the child under the HV Pilot Project, the encounter rate for each home**

visit provided to participating beneficiaries will increase to \$176.00 per home visit.

The SCDHHS anticipates that the investment in the enhanced services provided through the HV Pilot Project will lead to improved birth outcomes and greater overall cost savings in the future. Over thirty years of extensive research and multiple randomized controlled trials have demonstrated that the NFP model consistently produces measurable improvements in several targeted metrics, including improved prenatal health, increased intervals between first and second pregnancies, reductions in women’s use of welfare, improved school readiness and academic achievement for children, as well as reductions in overall costs to government. Please refer to Section D of this waiver application for more information regarding the HV Pilot Project cost-effectiveness analysis detailing the State’s anticipated savings resulting from the provision of enhanced services at the increased reimbursement rate.

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):

\_\_\_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

X **Open** cooperative procurement process (in which any qualifying contractor may participate)

Application: Managed Care Initiative Only

\_\_\_ **Sole source** procurement

X **Other** (please describe)

Application: HV Pilot Project Only

**HV PILOT PROJECT:**

All HV Pilot Project services will be provided by provider agencies in South Carolina affiliated with the Nurse-Family Partnership National Service Office, the sole licensee of the trademarked NFP model. While the State will contract with any Medicaid provider meeting the above listed criteria, for purposes of evaluation and reporting, all HV Pilot Project providers must be enrolled in the pilot at the beginning of the waiver period. Thus, at this time, the SCDHHS intends to contract with all nine (9) of the existing NFP affiliated provider agencies in the state, which include four (4) South Carolina Department of Health and Environmental Control public health

**departments, three (3) healthcare organizations, one (1) federally qualified health center and one (1) rural health clinic.**

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

### 1. Assurances.

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

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

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

- Two or more MCOs **MANAGED CARE INITIATIVE ONLY**
- 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). **HV PILOT PROJECT ONLY**
- Beneficiaries will be given a choice of providers in their service area.

### HV PILOT PROJECT:

**HV Pilot Project beneficiaries will only be able to access the enhanced prenatal, postpartum and infant home visitation services available through this waiver if they live in an area serviceable by a local NFP provider. The**

**following counties will be included in this waiver: Abbeville, Anderson, Barnwell, Berkeley, Charleston, Colleton, Darlington, Dillon, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Horry, Lexington, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union and Williamsburg Counties.**

**In addition, the NFP provider agencies will retain discretion on a case by case basis to determine whether it is feasible, based on geographic restrictions, for the provider to serve a referred beneficiary who resides outside of one of the above listed serviceable counties. SCDHHS will encourage providers to use reasonable efforts to serve beneficiaries who are interested in accessing the HV Pilot Project services regardless of whether the individual lives outside one of the explicitly included counties.**

**Each eligible beneficiary randomly selected to participate in the HV Pilot Project will be assigned to the single NFP agency providing services to the eligible beneficiary's county. While a participating beneficiary will be limited to a single NFP provider in their county, the beneficiary will be allowed to request changes to the specific registered nurse providing home visit services through the single NFP provider agency. In addition, although beneficiaries are assigned to a single NFP provider agency, the HV Pilot Project remains a voluntary program, and beneficiaries may elect to stop participating in the pilot project at any time.**

**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

**Application: Managed Care Initiative Only**

**Less than Statewide**

**Application: HV Pilot Project Only**

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.

**MCO INITIATIVE:**

<b>City/County/Region</b>	<b>Type of Program (PCCM, MCO, PIHP, or PAHP)</b>	<b>Name of Entity (for MCO, PIHP, PAHP)</b>
<b>Statewide</b>	<b>MCO</b>	<b>Select Health of South Carolina</b>
<b>Statewide (except Cherokee County)</b>	<b>MCO</b>	<b>Wellcare</b>
<b>Statewide</b>	<b>MCO</b>	<b>Centene Corporation</b>
<b>Statewide</b>	<b>MCO</b>	<b>BC/BS of South Carolina</b>
<b>Statewide</b>	<b>MCO</b>	<b>AdviCare</b>
<b>Statewide</b>	<b>MCO</b>	<b>Molina Healthcare South Carolina</b>

**HV PILOT PROJECT:**

<b>City/County/Region</b>	<b>Type of Program (PCCM, MCO, PIHP, or PAHP)</b>	<b>Name of Entity (for MCO, PIHP, PAHP)</b>
<b>Abbeville, Edgefield, Greenwood, Saluda, and McCormick Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>Carolina Health Centers, Inc.</b>
<b>Anderson County</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>South Carolina Department of Health and Environmental Control, Region 1</b>
<b>Berkeley, Charleston, Colleton, and Dorchester Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>South Carolina Department of Health and Environmental Control, Low Country Region</b>
<b>Darlington, Dillon, Florence, and Marlboro Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>McLeod Home Health</b>
<b>Georgetown, Horry, and Williamsburg Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>South Carolina Department of Health and Environmental Control, Pee Dee Region</b>
<b>Greenville, Oconee, and Pickens Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>Greenville Hospital System University Medical Center</b>
<b>Barnwell, Lexington, and Richland Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>South Carolina Department of Health and Environmental Control, Midlands Public Health Region</b>
<b>Orangeburg County</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>South Carolina Office of Rural Health</b>
<b>Spartanburg and Union Counties</b>	<b>HV Pilot Project Participating NFP Affiliated Agency</b>	<b>Spartanburg Regional Health Services District, Inc.</b>



## **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:

### **MCO INITIATIVE:**

**The following populations (subject to the exclusions listed in subsection E2 below) will be enrolled in managed care under this waiver:**

- **Females eligible under 42 CFR 435.110 who are aged 12-30 (in state payment category 59);**
- **Pregnant women eligible under 42 CFR 435.116 (in state payment category 87);**
- **CHIP children ages 0-23 months (in state payment category 88); and**
- **Infants and children eligible under 42 CFR 435.118 who are aged 0-23 months (in state payment categories 12, 59, and 88).**

### **HV PILOT PROJECT:**

**The HV Pilot Project will be operated as a pilot and therefore is subject to an annual maximum program cap (see Appendix D for annual maximum caps, which vary by year). The enhanced NFP services will be specifically targeted to individuals meeting the following criteria:**

- (i) **Medicaid eligibility under either 42 CFR 435.110 who are aged 12-30 (in payment category 59) or 42 CFR 435.116 (in payment category 87);**
- (ii) **Less than 28 weeks pregnant at the time of enrollment;**
- (iii) **Has not previously had a live birth; and**
- (iv) **Resides at an address that is accessible by an NFP provider agency.**

**Beneficiaries meeting the target criteria will be randomly selected to participate in the pilot project through the use of a randomized computer algorithm which will enroll only approximately sixty-six percent (66%) of targeted beneficiaries up to the annual program cap. In the event that referrals to the HV Pilot Project are less than or greater than current projections indicate, SCDHHS will alter the randomized algorithm to enroll a smaller/larger percentage of the eligible individuals.**

**The HV Pilot Project will also serve the children born to participating mothers (regardless of the specific Medicaid eligibility category of the child). Coverage for the eligible children will be effective upon the completion of the mother's sixty (60) day postpartum period until the eligible child reaches two (2) years of age.**

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

Mandatory enrollment  
**Managed Care Initiative Only (See description on page 17 for subset of population that is included)**

Voluntary enrollment  
**HV Pilot Project Only (Applies only to the infants and children ages 0-2 born to HV Pilot Project participants, as described on page 17)**

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

Mandatory enrollment  
**Managed Care Initiative Only (See description on page 17 for subset of population that is included)**

Voluntary enrollment  
**HV Pilot Project Only (Applies only to the pregnant women aged 12-30, as described on page 17)**

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

Mandatory enrollment  
 Voluntary enrollment

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

Mandatory enrollment  
 Voluntary enrollment  
**HV Pilot Project Only (Applies only to the infants and children ages 0-2 born to HV Pilot Project participants, as described on page 17)**

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

- Mandatory enrollment
- Voluntary enrollment

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.

- Mandatory enrollment
- X Voluntary enrollment

**HV Pilot Project (Applies only to the infants and children ages 0-2 born to HV Pilot Project participants, as described on page 17)**

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

**Managed Care Initiative Only (See description on page 17 for subset of population that is included)**

- X Voluntary enrollment

**HV Pilot Project Only (Applies only to the infants and children ages 0-2 born to HV Pilot Project participants, as described on page 17)**

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:

X **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))

**Application: Managed Care Initiative Only**

**Medicare eligible beneficiaries are identified in the MMIS system by their Medicare plan types and are excluded from enrollment in managed care. Please note as described below, although not eligible for managed care by virtue of dual eligibility status, Medicare dual eligible children ages 0-2 born**

**to an HV Pilot Project participant are not excluded from participating in the HV Pilot Project.**

\_\_\_ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

\_\_\_ **Other Insurance**--Medicaid beneficiaries who have other health insurance.

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

**Application: Managed Care Initiative Only**

**Medicaid beneficiaries residing in nursing homes or other institutional settings are excluded from enrollment in managed care. However, the MCOs are responsible for paying for the first ninety (90) days of institutional care for its members. Medicaid MCO members are disenrolled and transferred to fee for service coverage following ninety (90) days of continuous confinement.**

\_\_\_ **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

\_\_\_ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

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

**Application: Managed Care Initiative Only**

**Home and Community Based Services Waiver beneficiaries are excluded from enrollment in managed care.**

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

**Application: Managed Care Initiative Only**

**Tribal members are identified by Indian Health Service providers and associated claims are paid under the fee-for-service system. However, members may be voluntarily enrolled in managed care.**

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

\_\_\_ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

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

X **Other** (Please define):

**MANAGED CARE INITIATIVE:**

**Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50 will not be mandatorily enrolled in managed care under this waiver. Also, this waiver is limited to specific age groups within each identified population. Specifically, as described on page 17, only the following subpopulations will be enrolled in managed care under this waiver:**

- **Females eligible under 42 CFR 435.110 who are aged 12-30 (in payment category 59);**
- **Pregnant women eligible under 42 CFR 435.116 (in payment category 87);**
- **CHIP children ages 0-23 months (in payment category 88); and**
- **Infants and children eligible under 42 CFR 435.118 who are aged 0-23 months.**

**HV PILOT PROJECT:**

**Individuals who either do not meet the criteria for the HV Pilot Project (as defined on page 17) or were not selected to participate in the HV Pilot Project in accordance with the State’s random algorithm are excluded from participation in the HV Pilot Project and the identified 1915(b)(3) services. Instead, such individuals will be eligible to receive standard State Plan home visit services as medically necessary.**

## 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.
- X 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.

### HV PILOT PROJECT ONLY:

**All services provided under the HV Pilot Project are supplemental 1915(b)(3) services that are not otherwise covered in the State Plan. Therefore, the services available under the waiver for the HV Pilot Project participants only will be available in a greater amount, duration and scope than under the State Plan.**

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

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

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

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

- The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services. **Application: HV Pilot Project Only**

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

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

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

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

**Application: HV Pilot Project Only**

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:

**Application: Managed Care Initiative Only**

**All MCOs contract with at least one FQHC. The State continually monitors FQHC access to ensure that the MCO has adequate capacity and range of services to provide all covered services for the expected enrollment in the MCOs services area.**

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

5. **EPSDT Requirements.**

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

**Application: Managed Care Initiative Only**

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.



**HV PILOT PROJECT ONLY:**

**The State Plan currently provides for postpartum home visits focused on the needs of the mother and infant within six (6) weeks after delivery. The existing State Plan postpartum home visit benefit covers a maximum of two (2) home visits, and includes the following services:**

- **Medical assessment of the postpartum mother and infant;**
- **Assessment of household components to determine barriers to health;**
- **Counseling regarding postpartum recovery, family planning, needs of a newborn; and**
- **Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled).**

**The HV Pilot Project will expand these services for eligible beneficiaries randomly selected to participate in the HV Pilot Project. All 1915(b)(3) services are medical or health-related care, or other services as described in 42 CFR Part 440. Under the HV Pilot Project, the home visitation benefit will be available to the participating beneficiaries during their pregnancy and sixty (60) day postpartum period. In addition, home visitation services will be provided to the infant(s) born to the participating beneficiary beginning upon the expiration of the mother's sixty (60) day postpartum benefits for a period of up to two (2) years following the child's birth.**

**HV Pilot Project participating families are eligible to receive up to forty (40) home visits during the participating family's total period of eligibility, which will be comprised of the following services:**

- **No more than fifteen (15) prenatal home visits;**
- **No more than eight (8) postpartum home visits; and**
- **No more than seventeen (17) total home visits for the eligible child (to be used prior the date the eligible child reaches two (2) years of age).**
-

Service	Description of Service	Provider Type/ Qualifications	Populations Eligible	Geographic Availability	Reimbursement Method
Prenatal Home Visit	<p>The HV Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide:</p> <ul style="list-style-type: none"> <li>• Monitoring for high blood pressure or other complications of pregnancy;</li> <li>• Diet and nutritional education;</li> <li>• Stress management;</li> <li>• STD prevention education;</li> <li>• Tobacco use screening and cessation education;</li> <li>• Alcohol and other substance misuse screening and counseling;</li> <li>• Depression screening; and</li> <li>• Domestic and intimate partner violence screening and education.</li> </ul>	<p>Contracting organizations must:</p> <ul style="list-style-type: none"> <li>• Be a Medicaid enrolled provider;</li> <li>• Be affiliated with the NFP National Service Office; and</li> <li>• Implement the NFP home visitation model in providing services to HV Pilot Project beneficiaries.</li> </ul>	<p>Medicaid eligible persons who are pregnant and meet the HV Pilot Project selection criteria described in subsection E of this Part I.</p>	<p>Abbeville, Anderson, Barnwell, Berkeley, Charleston, Colleton, Darlington, Dillon, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Horry, Lexington, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union and Williamsburg Counties.</p>	<p>Fee for Service</p>
Post-Partum Home Visit	<p>The HV Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period. The postpartum home visit services will include the basic home visit services included under the State Plan along with the following service enhancements:</p> <ul style="list-style-type: none"> <li>• Diet and nutritional education;</li> <li>• Stress management;</li> <li>• STD prevention education;</li> <li>• Tobacco use screening and cessation education;</li> <li>• Alcohol and other substance misuse screening and counseling;</li> <li>• Depression screening;</li> <li>• Domestic and intimate partner violence screening and education;</li> <li>• Breastfeeding support and education; and</li> </ul>	<p>Contracting organizations must:</p> <ul style="list-style-type: none"> <li>• Be a Medicaid enrolled provider;</li> <li>• Be affiliated with the NFP National Service Office; and</li> <li>• Implement the NFP home visitation model in providing services to HV Pilot Project beneficiaries.</li> </ul>	<p>Medicaid eligible persons who are less than 60 days postpartum and meet the HV Pilot Project selection criteria described in subsection E of this Part I.</p>	<p>Abbeville, Anderson, Barnwell, Berkeley, Charleston, Colleton, Darlington, Dillon, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Horry, Lexington, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union and Williamsburg Counties.</p>	<p>Fee for Service</p>

Service	Description of Service	Provider Type/ Qualifications	Populations Eligible	Geographic Availability	Reimbursement Method
	<ul style="list-style-type: none"> <li>Guidance and education with regard to well woman visits to obtain recommended preventive services.</li> </ul>				
Infant Home Visit	<p>The HV Pilot Project will provide home visit services to newborn infants born to HV Pilot Project beneficiaries until the child reaches two (2) years of age. The infant home visit services will include the basic home visit services included under the State Plan for up to two years following the child’s birth in addition to the following service enhancements:</p> <ul style="list-style-type: none"> <li>Breastfeeding support and education; and</li> <li>Child developmental screening at major developmental milestones from birth to age two (2).</li> </ul>	<p>Contracting organizations must:</p> <ul style="list-style-type: none"> <li>Be a Medicaid enrolled provider;</li> <li>Be affiliated with the NFP National Service Office; and</li> <li>Implement the NFP home visitation model in providing services to HV Pilot Project beneficiaries.</li> </ul>	<p>Medicaid or CHIP eligible persons less than two (2) years of age who meet the HV Pilot Project selection criteria described in subsection E of this Part I.</p>	<p>Abbeville, Anderson, Barnwell, Berkeley, Charleston, Colleton, Darlington, Dillon, Dorchester, Edgefield, Florence, Georgetown, Greenville, Greenwood, Horry, Lexington, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Union and Williamsburg Counties.</p>	<p>Fee for Service</p>

## 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:

### MCO INITIATIVE ONLY:

The following services are available to waiver enrollees on a self-referral basis:

- *Emergency Services* – In accordance with 42 CFR 422.113, the MCOs provide members with access to emergency services without requiring prior authorization or primary care physician referral, regardless of whether these services are provided by a contract or non-contract provider. Post-stabilization services will be provided consistent with 42 CFR 422.113(c)(2).
- *Family Planning Services* – In accordance with 42 CFR 431.51(b)(2), the MCOs provide members with access to providers of family planning services without requiring prior authorization or primary care physician referral, regardless of whether these services are provided by a contract or non-contract provider.
- *Women's Health* – In accordance with 42 CFR 438.206(b)(2), the MCOs provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services.
- *EPSDT* – The MCOs provide members with access EPSDT screening services without prior authorization or a primary care physician referral.

## 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.

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

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

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

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

2. Details for PCCM program. 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. N/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. **N/A 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. **N/A 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. N/A **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.

**HV PILOT PROJECT ONLY:**

**In order to participate in the HV Pilot Project, the provider must follow the Nurse Family Partnership (NFP) model, including appropriately timed home visits in accordance with the current NFP guidelines. While the guidelines establish a recommended schedule for prenatal, postpartum and infant home visits, the guidelines provide flexibility for the visiting nurse to also consider the individual needs of the family when scheduling home visits. The provider agencies will be required to develop and implement written policies and procedures to ensure beneficiaries receive timely access to appropriate home visit services tailored to the specific needs of each beneficiary. While these policies and procedures are agency-specific, the agency is responsible for ensuring the policies and procedures are consistent with the NFP program requirements.**

**While the timing of each individual beneficiary's home visits may vary, the State expects that each new beneficiary will receive an initial assessment and home visit in a timely manner after being referred and approved for participation in the HV Pilot Project. Specifically, the provider agency is required to contact the beneficiary and schedule the initial assessment within one (1) week of receiving a referral. At least fifty percent (50%) of all HV Pilot Project beneficiaries are expected to receive their first home visit within one (1) week of the initial assessment, and all beneficiaries must receive their first home visit within two (2) weeks of the initial assessment. In addition, all HV Pilot Project beneficiaries must receive their first home visit prior to the end of the twenty-eighth (28<sup>th</sup>) week of pregnancy. The State will require all participating NFP provider agencies to report on the above listed timeliness standards on an annual basis to the SCDHHS. When it is determined a provider agency is out of compliance, SCDHHS will require the agency to submit a corrective action plan within thirty (30) days. This plan must show the steps the provider agency is taking to ensure agency staff members are**

**completing to assure remediation. The plan may include additional training, adjusting the RN's case load sizes, and/or setting up a system to monitor service access and utilization.**



## 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. N/A The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. N/A The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. N/A 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. N/A The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

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

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

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

f. N/A **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.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>

<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. N/A 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.

**HV PILOT PROJECT:**

**On average, eight hundred (800) new pregnant Medicaid beneficiaries will be enrolled in the HV Pilot Project each year for the first four (4) years of the pilot project. Currently, NFP affiliated providers operate in twenty-six (26) counties, which comprises over half the counties in the state. At a minimum, the HV Pilot Project will operate in these twenty-six (26) counties; however, the providers will also retain discretion to serve beneficiaries in surrounding counties if the provider determines that the beneficiary’s address is accessible by the provider.**

**The current NFP affiliated providers in the State have the ability to serve the HV Pilot Project at full program capacity. All full-time nurse home visitors will be required to carry a caseload of no more than twenty-five (25) active beneficiaries. This client ratio is a requirement for the provider to maintain its NFP affiliation, and is regularly monitored by the NFP National Service Office. Based on this client ratio limit, a total of thirty-two (32) nurses would be required to serve eight hundred (800) new beneficiaries each year that the HV Pilot Project is enrolling new participants. The existing NFP providers in the State currently have forty-eight (48) registered nurses trained in the NFP model. This analysis indicates that there is currently a sufficient number of NFP affiliated providers to meet the needs of the HV Pilot Project participating beneficiaries.**

## 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. N/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.

#### MANAGED CARE INITIATIVE ONLY:

The SCDHHS identifies patients with special health care needs using the 3M™ Clinical Risk Grouping (CRG) software. This approach allows SCDHHS to identify individuals within catastrophic 3M CRGs, individuals with metastatic malignancies, individuals with multiple significant co-morbid diseases, and individuals with a single dominant or moderate chronic disease. SCDHHS provides this information to each

**MCO monthly. Using this data, along with additional techniques, the MCO is required to provide care management, wellness promotion, and illness prevention activities based on the healthcare conditions and risks identified through this process.**

**Each MCO must submit a monthly report of all beneficiaries who are receiving care management services from the MCO. This report facilitates SCDHHS oversight of the MCO care management processes and their inclusion of beneficiaries with special healthcare needs.**

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

**MANAGED CARE INITIATIVE ONLY:**

**Individuals identified to the MCO by the SCDHHS as having special health care needs must be assessed by the MCO in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. MCOs are required to use a comprehensive assessment methodology that includes evaluation of claims data, coordination with the beneficiary's primary and specialty care providers, and direct contact with the beneficiary and appropriate caregivers.**

- d.  **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1.  Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
  2.  Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
  3.  In accord with any applicable State quality assurance and utilization review standards.
- e.  **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow

enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program.** 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. **N/A** Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. **N/A** 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. **N/A** Each enrollee is receives **health education/promotion** information. Please explain.
- d. **N/A** Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. **N/A** There is appropriate and confidential **exchange of information** among providers.
- f. **N/A** Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. **N/A** 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. **N/A** **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. **N/A** **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.

**HV PILOT PROJECT:**

**The State does not anticipate any negative impact to coordination or continuity of care due to the fact that HV Pilot Project participants are not losing access to any services, but rather are receiving additional services. In fact, the enhancements to the home visit services are expected to improve coordination and continuity of care for first time mothers and their children by encouraging receipt of appropriate post-partum and well child visit care.**

## 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 is currently being developed and is targeted for submission to the CMS Regional Office prior to the implementation of this waiver.**

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	Carolinas Center for Medical Excellence	X	X	X



2. **Assurances For PAHP program.**

**N/A** 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.

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

b. **N/A 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. **N/A 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. N/A **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:

**HV PILOT PROGRAM:**

**All services for the HV Pilot Project will be provided by Medicaid enrolled provider agencies in South Carolina affiliated with the Nurse-Family Partnership National Service Office, the sole licensee of the trademarked NFP model. To maintain the required NFP affiliation, all providers must maintain fidelity to the NFP model, including the service delivery guidelines supporting the model. The NFP National Service Office continuously monitors its affiliated agencies through the use of continuous quality improvement tools and regular reporting focused on program implementation and outcomes. Specifically, the NFP National Service Office provides nurse consultants to meet with nurse supervisors on a monthly basis to review data and reporting, support implementation of the NFP model, and provide professional development. In addition, the nurse consultants conduct annual site visits of the NFP affiliated provider agencies to ensure that the program is being implemented in accordance with the agency's implementation plan and with fidelity to the NFP model.**

**In addition to the NFP National Service Office oversight, each contracted provider agency will be responsible for monitoring the performance of all**

**registered nurses providing direct services to HV Pilot Project beneficiaries to ensure compliance with all NFP quality standards, and to take appropriate action in the case of failure to comply.**

**During the five (5) year waiver period, the State will assure quality through continuous monitoring of program implementation and process measures. Specifically, the HV Pilot Project providers will be required to ensure that all pilot project services are provided by registered professional nurses who are appropriately trained in the NFP model. In addition, the providers will be required to ensure that all nurses have access to nurse supervisors who have completed the core NFP education sessions. The State and the NFP National Service Office will ensure that quality services are provided to HV Pilot Project beneficiaries by regularly monitoring the provider processes to ensure that services are provided in strict accordance with the evidence based NFP model.**

**Ultimately, however, the purposes of the HV Pilot Project is to achieve improved birth and health outcomes. Therefore, SCDHHS will continuously track and monitor quality outcomes for purposes of conducting a rigorous independent evaluation of the HV Pilot Project. As part of the performance review of the pilot project, the SCDHHS will collect and analyze quality data related to the following targeted benchmark areas:**

- **Pregnancy-induced hypertension;**
- **Incidence of preterm birth;**
- **Inter-birth intervals;**
- **Breastfeeding;**
- **Well-child visits;**
- **Child immunization;**
- **Child hospitalizations;**
- **Child emergency department admissions; and**
- **Total Medicaid expenditures among mothers and children.**

## 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

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

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

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

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

##### 2. Details

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

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

**Application: Managed Care Initiative and HV Pilot Project**

**Permitted indirect marketing activities include mass media advertising such as radio, television, and billboards.**

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

**Application: Managed Care Initiative and HV Pilot Project**

**Permitted direct marketing activities include direct mail advertisements, direct phone and web outreach to alert beneficiaries about the programs, and participation in community oriented marketing efforts (i.e., community health fairs).**

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

1.  The State prohibits or limits 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.

**Application: Managed Care Initiative Only**

**MCOs are encouraged to participate in community health fairs. Gifts of nominal value may be distributed at such events to potential enrollees. Gifts or other incentives to potential enrollees are limited to a \$10.00 maximum value. MCOs are subject to penalties under the Social Security Act §1128(a)(5) regarding inducements, remunerations, and gifts to Medicaid recipients, and must comply with all marketing provisions in 42 CFR 438.104. The State monitors MCO activities by requiring approval of all marketing materials and plans prior to distribution.**

2.  The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3.  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):

**Application: Managed Care Initiative and HV Pilot Project**

**The MCOs and HV Pilot Project providers will be required to provide all written marketing materials in English and Spanish. Per the contract with the State, all MCOs are required to ensure that where at least five percent (5%) or more of the resident population of a county is non-English speaking and speaks a specific foreign language, materials will be made available in that specific language.**

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

- i.  The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii.  The languages comprise all languages in the service area spoken by approximately **five percent (5%)** or more of the population.
- iii.  Other (please explain):

## B. Information to Potential Enrollees and Enrollees

### 1. Assurances.

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

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

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

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

### 2. Details.

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

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

#### **Application: Managed Care Initiative and HV Pilot Project**

**The MCOs and HV Pilot Project providers will be required to provide all potential enrollee and enrollee materials in Spanish, or any other prevalent non-English language that may be identified by the State.**

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.”

**The State defines “significant” as the single most frequently requested non-English language.**



2. \_\_\_ The languages spoken by approximately \_\_\_ 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.

**Application: Managed Care Initiative**

**MCOs are contractually required to provide language interpreter and translation services to any member, free of charge, who needs such services, including, but not limited to members with limited English proficiency and member who are hearing impaired. Interpreter services must be made available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line. The State operates a Language Line for translation services. Most of the MCOs currently utilize this resource for the provision of oral translation services to members.**

**Application: HV Pilot Project**

**When oral translation services are required, the language is identified and the State’s Language Line is contacted for translation services. However, several of the NFP providers have the capacity to provide Spanish speaking nurses trained in the NFP model to Spanish speaking beneficiaries.**

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

**Application: Managed Care Initiative Only**

**The State utilizes an Enrollment Broker to assist enrollees and potential enrollees understand the managed care program, including the member’s choice of MCOs, how to access benefits, and information on available providers.**

**b. Potential Enrollee Information**

Information is distributed to potential enrollees by:

- X State (**HV Pilot Project Only**)
- X Contractor (please specify): (**Managed Care Initiative and HV Pilot Project**)

**MANAGED CARE INITIATIVE:**

**The State contracts with an enrollment broker to distribute information regarding the state’s managed care programs to potential enrollees.**

**HV PILOT PROJECT:**

**NFP-affiliated providers will be responsible for distributing information to potential enrollees regarding the HV Pilot Project.**

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

**c. Enrollee Information**

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

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

**MANAGED CARE INITIATIVE:**

**The MCOs are responsible for distributing required program information to their enrollees, such as the member handbook. Each MCO is required to maintain a comprehensive member services function to assist their members in understanding the MCO's policies and procedures, and provide additional information about the network providers, facilitate referrals, and assist in the resolution of service and/or medical delivery concerns or problems.**

**HV PILOT PROJECT:**

**NFP-affiliated providers will be responsible for distributing required information to enrollees participating in the HV Pilot Project.**

## C. Enrollment and Disenrollment

### 1. Assurances.

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

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

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

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

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

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

#### MANAGED CARE INITIATIVE:

**The State contracts with an enrollment broker to provide ongoing education and outreach to potential enrollees, including information about the basic features of managed care and program options. In addition, the MCOs participate in community oriented marketing efforts (i.e., community health fairs) as well as indirect marketing efforts to inform potential enrollees of the managed care program.**

#### HV PILOT PROJECT:

**Utilizing eligibility data linked to the individual's vital records data, The South Carolina Department of Health and Human Services**

(SCDHHS) will directly identify and refer all potentially eligible first time pregnant Medicaid beneficiaries to participate in the HV Pilot Project. In addition, beneficiaries may also self-refer to the HV Pilot Project or may be referred by healthcare providers, managed care organizations and other community organizations. Further, upon the implementation of the HV Pilot Project, the Nurse-Family Partnership National Service Office, with support from local foundation partners, will implement a grassroots outreach effort to promote the program and identify other high-risk individuals potentially eligible for the program, particularly targeting individuals living in specific low-income zip codes or who may otherwise be overlooked in the traditional health care system.

All referrals will be directed to the appropriate NFP provider or to the NFP National Service Office for assignment to the appropriate NFP provider based on the individual's geographic location. Once the referral is received by the local NFP provider agency, the provider will conduct outreach to the individual and provide information to the potential beneficiary regarding the HV Pilot Project to determine if the individual would be interested in participating in the pilot.

**b. Administration of Enrollment Process.**

- State staff conducts the enrollment process.
- The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
- The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

**Managed Care Initiative Only**

Broker name: MAXIMUS

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other (please describe):
- Materials fulfillment
  - Member MCO transfers
  - Member Disenrollment

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

**HV Pilot Project Only:**

**The NFP Provider agencies will manage the HV Pilot Project enrollment process. Once the referral is received by the local NFP provider agency, the provider will conduct outreach to the individual to determine if the individual would be interested in participating in the HV Pilot Project.**

**If a referred individual expresses an interest in participating in the HV Pilot Project, the NFP provider will schedule the initial assessment. During the initial assessment, the provider will obtain required beneficiary information and consent to participate in the pilot evaluation. This initial assessment will not be reimbursed by SCDHHS.**

**Following completion of the initial assessment, the provider will utilize software that randomly assigns the individual to participate in the HV Pilot Project or to receive standard State Plan services through the individual's managed care entity. The random algorithm is set to sixty-six percent (66%) probability of receiving the enhanced HV Pilot Project services. The application software is entirely randomized and tamper-proof. The results of the assignment will be shared with SCDHHS and the program evaluator.**

**SCDHHS will continuously monitor the results of the randomized software, and, if necessary, alter the algorithm if more/less beneficiaries are referred to the program than current projections indicate.**

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

- X 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.):

**MANAGED CARE INITIATIVE:**

**The SCDHHS currently operates a comprehensive managed care program through state plan authority. All of the populations transitioning to managed care authority under this 1915(b) waiver are currently covered under managed care. This waiver is a technical revision to the underlying managed care authority, and will not result in any programmatic**

**changes for the current enrollees. Therefore, no implementation plan is required for the managed care initiative component of this waiver.**

**HV PILOT PROJECT:**

**The HV Pilot Project will be implemented in all participating regions on the targeted implementation date of January 1, 2016. However, eligible beneficiaries will be identified and enrolled on a rolling basis during the first four (4) years of the five (5) year waiver, rather than immediately on the date of implementation.**

— 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.

**Application: Managed Care Initiative Only**

- i. **X** Potential enrollees will have **60 days** 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.

**Managed Care Initiative:**

**The default assignment of beneficiaries to managed care health plans is performed by the State's enrollment broker on a monthly basis utilizing a customized assignment algorithm. The process links beneficiaries with available health plans in their geographical area and ensures that there is a choice of health plans where appropriate, should the beneficiary request a transfer. The assignment process also ensures that beneficiaries are assigned to an MCO in their geographic region that is accepting new members. The distribution of these beneficiaries to the health plans occurs through the use of a leveling procedure designed to equitably assign beneficiaries across all of the available plans in the geographic area. The procedure maintains family relationships whenever possible to minimize confusion.**

- \_\_\_ 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 2 months or less. **Managed Care Initiative Only**

**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.

**Managed Care Initiative Only**

- i. **X** Enrollee submits request to State. **Member initiated disenrollment requests may be oral, written or electronic and must be made to the State’s enrollment broker. The State reviews and approves all disenrollment requests.**
- 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):

**Managed Care Initiative Only**

**A managed care enrollee may only transfer MCOs during the lock-in period for any of the good cause circumstances detailed in 42 CFR 438.56(c).**

— 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:

**Application: Managed Care Initiative Only**

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

- **Member has Medicare coverage**
- **Member has enrolled in hospice**
- **Member has enrolled in a home/community waiver program**
- **Member resides in a long term care facility**
- **Member is placed in a treatment facility**
- **Member is an inmate**
- **Member moves out of the MCO catchment area**
- **Member has died**
- **Member’s behavior is disruptive or uncooperative and this impairs the MCOs ability to furnish services the member requires**

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.

**HV PILOT PROJECT DISENROLLMENT PROCESS:**

**HV Pilot Project beneficiaries may disenroll from the pilot project at any time during the course of the individual's period of eligibility. Individuals who disenroll from the HV Pilot Project will no longer be eligible for the 1915(b)(3) waiver enhanced home visit services. However, such individuals may be eligible to access the traditional State Plan postpartum home visit services from their managed care entity.**

**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.

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.

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

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

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

3. **Details for MCO or PIHP programs. (MANAGED CARE INITIATIVE ONLY)**

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

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

**b. Timeframes**

- The State’s timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal is at least 30 days** (between 20 and 90).
- The State’s timeframe within which an enrollee must file a **grievance is at least 30 days**.

**Each MCO’s grievance and appeals procedure are reviewed and approved by the State, and include the minimum requirements set forth in the contracts, including compliance with 42 CFR § 438.400, et seq. The contracts require that a managed care enrollee be allowed at least thirty (30) calendar days from receipt of notice of MCO action to respond to the notice.**

**c. Special Needs**

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

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

**N/A** 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):

**HV PILOT PROJECT GRIEVANCE AND APPEAL PROCESS:**

**HV Pilot Project participants will have access to the State’s fair hearing process, and are able to file grievances and appeals specific to the HV Pilot Project directly with the SCDHHS. To clarify, managed care beneficiaries participating in the HV Pilot Project are not required to exhaust their MCO grievance and appeal process before requesting a state fair hearing for issues related to the 1915(b)(3) services obtained through participation in the pilot. All HV Pilot Project participants will be notified of their grievance and appeal rights upon enrollment in the pilot.**

## 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 excluded under 1128(b)(8) as being controlled by a sanctioned individual.

### 2. Assurances For MCO or PIHP programs

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

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

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

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



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

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

## **I. Summary Chart of Monitoring Activities**

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

**Managed Care: “MCO”**

**HV Pilot Project: “HVP”**

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

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



## II. Details of Monitoring Activities

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

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

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

- a.  Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

- NCQA  
 JCAHO  
 AAAHC  
 Other (please describe)

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

- NCQA (**MANAGED CARE INITIATIVE**)  
 JCAHO  
 AAAHC  
 Other (please describe) (**HV PILOT PROJECT**)

### **Managed Care Initiative:**

**MCOs must attain and maintain at least the "Commendable" level of accreditation from the National Committee for Quality Assurance (NCQA) as a condition for providing services to South Carolina Medicaid beneficiaries.**

### **HV Pilot Project:**

**Contracted providers must attain and maintain formal affiliation with the Nurse-Family Partnership National Service Office. The NFP affiliation must be maintained throughout the**

**life of the provider’s contract with the State. The NFP National Service Office conducts detailed and regular quality reviews of its affiliated agencies to ensure that the agencies are implementing the program with fidelity to the NFP model, including the timely access and quality standards required by the NFP guidelines and overarching NFP model.**

c. X

Consumer Self-Report data

X CAHPS (please identify which one(s))

- **NCQA HEDIS CAHPS 5.0H Adult Medicaid Health Plan Survey**
- **NCQA HEDIS CAHPS 5.0H Child Medicaid Health Plan Survey**

\_\_\_ State-developed survey

\_\_\_ Disenrollment survey

\_\_\_ Consumer/beneficiary focus groups

**Managed Care Initiative:**

**MCOs are required to monitor beneficiary perceptions of accessibility and adequacy of services provided by the MCO. The MCOs are required to utilize the NCQA Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which serves as the tool for evaluating beneficiary satisfaction. The survey is utilized to assess member experiences as reported with their MCO as an indicator of quality and member satisfaction with care. Specifically, the survey monitors the following aspects of care: member choice, marketing, member enrollment and disenrollment, information to beneficiaries, member grievances, timely access, coordination and continuity of care, coverage and authorization, as well as quality of care. In addition, MCOS may also employ additional tools to supplement the CAHPS survey. These tools may include the use of additional anecdotal information gathered through communications with beneficiaries, provider interactions, grievance and appeals data, and enrollment and disenrollment information.**

**MCOs are required to submit the results of the CAHPS survey, along with the results of any other member satisfaction measurements, to SCDHHS annually. State staff review the survey results, and any problems, issues, or discrepancies identified are acted upon promptly.**

d. X

Data Analysis (non-claims)

\_\_\_ Denials of referral requests

- X Disenrollment requests by enrollee
  - X From plan
  - \_\_\_ From PCP within plan
- X Grievances and appeals data
- \_\_\_ PCP termination rates and reasons
- \_\_\_ Other (please describe)

**Managed Care Initiative:**

**Disenrollment and transfer requests are evaluated on a monthly and quarterly basis by SCDHHS and its contracted enrollment broker. These enrollment reports are monitored closely to ensure that MCO enrollment trends do not indicate issues with access to care or beneficiary satisfaction. Specifically, the data is utilized to monitor member choice, enrollment/disenrollment, information to beneficiaries, grievances, timely access, and PCP capacity. In addition, MCOS are required to provide SCDHHS with a monthly written log of all active and resolved grievances and appeals filed by Medicaid beneficiaries. Through these reports, potential problems may be quickly identified and communicated to each MCO for resolution. SCDHHS may enforce corrective actions if identified program issues are not resolved.**

**HV Pilot Project:**

**The SCDHHS will maintain member enrollment and disenrollment information, as well as grievance and appeal data. In addition, the providers will be contractually required to submit regular reports to the SCDHHS regarding the volume and timely resolution of beneficiary grievances. This data will be analyzed to identify trends and ensure quality services are provided to beneficiary.**

- e. X Enrollee Hotlines operated by State

**Managed Care Initiative and HV Pilot Project:**

**SCDHHS operates and maintains a toll-free hotline staffed by the Medicaid Customer Services Unit to provide general assistance to all Medicaid beneficiaries. The State is able to monitor all calls made to this line in order to identify non-compliance or other program concerns specific to managed care, the performance of an MCO, or the HV Pilot Project. The Medicaid Customer Service Unit is able to forward questions and/or problems from providers and beneficiaries to the appropriate SCDHHS division for prompt resolution.**

**MCOs are required to include information about the beneficiary hotline in the member handbook.**

- 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. X Geographic mapping of provider network

**Managed Care Initiative**

**The SCDHHS utilizes geographic mapping techniques in the evaluation of MCO network adequacy. The geo-mapping software program produces a report allowing the State to identify provider distribution by type across the service area, including an analysis and evaluation of primary care providers, specialists, institutions, and ancillary service providers. The State analyzes this information to monitor member choice, timely access, PMP/specialist capacity, and provider selection. The geographic mapping of MCO provider networks is completed on a semi-annual basis and reviewed by the SCDHHS contract monitoring staff. In the event deficiencies are identified, the State may limit a MCO's ability to operate within the affected county/ counties.**

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

**HV Pilot Project:**

**An independent entity, J-PAL North America (a research organization housed within the Economics Department at MIT) will conduct the independent assessment of the HV Pilot Project on behalf of the State. Providers will be required to cooperate with J-PAL in implementing evaluation-specific procedures. The State will submit the initial findings to CMS when renewing the waiver program.**

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

**Managed Care Initiative:**

**The general managed care program assessment conducted by SCDHHS and its analytics vendor often includes measures of racial or ethnic disparities. In the event of identified**



**deficiencies, a corrective action plan or other contractually agreed upon remedy is required.**

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

**Managed Care Initiative:**

**The MCOs are contractually required to establish and maintain, through written agreements, an appropriate network of providers. Further, the MCOs are required to submit documentation that its provider network meets adequacy requirements, in accordance with 42 CFR §438.207. Specifically, documentation is required to be submitted (i) prior to an MCO entering a new geographic area, (ii) biannually (February and August of each year), (iii) upon significant changes in the network, and (iv) as requested by SCDHHS.**

- k. \_\_\_\_\_ Ombudsman

- l.  X  On-site review

**Managed Care Initiative:**

**On-site reviews are performed annually for each contracted MCO by the State’s External Quality Review Organization (EQRO). Site visits include but are not limited to review of quality outcomes, as well as timeliness of and access to the services covered under the MCO’s contract with the State. The MCO is required to provide information necessary to complete the review as requested by the SCDHHS or its designee. The on-site reviews are utilized to review MCO compliance with federal and state regulations, contract requirements, managed care policies and procedures, and quality improvement activities. If deficiencies are identified during the on-site review, the MCO must submit a corrective action plan for approval addressing how the MCO will remediate the deficiencies and the timeframe in which such deficiencies will be corrected.**

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

**Managed Care Initiative:**

**The MCOs are required to conduct performance improvement projects (PIPs). The PIPs are utilized to monitor and improve,**

**through ongoing measurements and intervention, the quality of care delivered to members. The MCOs are required to have an ongoing program of PIPs (a minimum of two projects) focusing on clinical and nonclinical areas, developed in accordance with 42 CFR 438.240, and designed to achieve significant improvement (sustained over time) in health outcomes and member satisfaction. Each PIP must be completed in a reasonable time period so as to generally allow aggregate information on the success of the PIP to produce new information on quality of care each year. The PIPs are reviewed on an ongoing basis by the state's EQRO.**

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

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

**Managed Care Initiative:**

**The MCOs are contractually required to report on a set of performance metrics, including but not limited to all Medicaid plan measures required by the NCQA for accreditation, as well as any additional measures required by the State. The scope of the performance monitoring measures include quality of care, access to care, care coordination reporting, and other metrics determined by the state. However, the State primarily uses NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measures to evaluate MCO performance. HEDIS results are reported by each MCO to SCDHHS annually. The results of the HEDIS measures are compared against the previous year's measurements to determine both current performance and overall improvement. The SCDHSS utilizes the HEDIS performance measures as the basis for the state's quality withhold program, as well as for quality-weighted auto-assignments.**

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

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

**HV Pilot Project:**

**The State does not expect many families to require services in excess of forty (40) total visits. The average number of home visits according to the standard NFP model would be approximately twenty four (24) total home visits during the family's eligibility period. The State will monitor encounter claims to identify any over-utilization patterns. When it is determined a provider agency is outside of standard utilization, the State (or its contracted vendor) will conduct concurrent desk and on-site audits of the provider.**

- q.  Provider Self-report data  
 Survey of providers  
 Focus groups
- r.  Test 24 hours/7 days a week PCP availability
- s.  Utilization review (e.g. ER, non-authorized specialist requests)

**HV Pilot Project:**

**Families participating in the HV Pilot Project are eligible to receive up to forty (40) home visits during the participating family's total period of eligibility. The total home visit service cap will be divided between mother and child. Participating mothers will have a service cap of fifteen (15) home visits to be used during pregnancy and eight (8) to be used during her postpartum period. Participating children will have a service cap of seventeen (17) total home visits to be used as needed until the child reaches two (2) years of age. Any claims in excess of the above listed service caps will be denied by the State and the NFP provider will not be eligible for Medicaid reimbursement.**

- t.  Other: (please describe)

**HV Pilot Project:**

**The contracted providers must submit all marketing and beneficiary communication materials to the State for review and approval prior to distribution. The State reviews for accuracy and compliance with state and federal requirements.**

**In addition, the contracted providers will be required to submit annual reports to the State regarding enrollment efforts and timely access to care. The State will review the provider reports to monitor member timely access to services, specifically to ensure that all beneficiaries are able to obtain an**

**initial service within two (2) weeks from the time the beneficiary was enrolled in the HV Pilot Project.**

## 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.

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes

\_\_\_\_ No. Please explain:  
Summary of results:  
Problems identified:  
Corrective action (plan/provider level)  
Program change (system-wide level)

## Section D – Cost-Effectiveness

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

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

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

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

### Part I: State Completion Section

#### A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
  - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
  - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
  - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
  - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
  - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

- Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State’s submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:  
**Adriana Day**
- c. Telephone Number: **803-898-0336**
- d. E-mail: **Adriana.Day@scdhhs.gov**
- e. The State is choosing to report waiver expenditures based on **X** date of payment.  
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

- B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.  
*Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*
- a.  The State provides additional services under 1915(b)(3) authority.
- b.  The State makes enhanced payments to contractors or providers.
- c.  The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d.  Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

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



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

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

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

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

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

**The 1915(b)(3) services proposed in this waiver will be provided through fee-for-service selective contracting as described in Section A.I.b.**

**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. N/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. N/A 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. N/A 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.  
**Base year member months reflect actual SFY 2014 membership for each MEG. The LIF MEG includes all females ages 12-30 in the Low Income Families payment category. The OCWI MEG includes all woman in the OCWI (pregnant woman) payment category. The Children 0-23 months MEG includes all children 0-23 months, with the exception that CHIP children 0-23 months are included in the CHIP MEG.**
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.  
**We estimate there will be approximately 2,033,155, 2,054,071, 2,075,225, 2,096,644, and 2,118,336 member months enrolled in the waiver program in prospective years 1 through 5, respectively. The estimated member months includes individuals enrolled in MCOs and fee-for-service individuals who will potentially be impacted by fee-for-service home visitation services.**  
**The HV pilot program is estimated to enroll 885, 661, 870, and 784 pregnant women in years 1 through 4, respectively.**
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:  
**Enrollment trends are consistent with trends estimated in the state of South Carolina’s Medicaid Assistance Forecast. These trends are estimated based on historical enrollment data and discussions with SCDHHS personnel.**
- d.  [Required] Explain any other variance in eligible member months from BY to P2:  
**Enrollment trends are consistent with trends estimated in the state of South Carolina’s Medicaid Assistance Forecast. These trends are estimated based on historical enrollment data and discussions with SCDHHS personnel.**
- e.  [Required] List the year(s) being used by the State as a base year:

**State Fiscal Year 2014.**

If multiple years are being used, please explain: \_\_\_\_\_

- f. X [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period  
**State Fiscal Year 2014, beginning in July 2013 and ending in June 2014.**
- g. X [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:  
**Capitation payments in SFY 2014 were estimated using SFY 2014 MCO membership multiplied by the capitation rates effective October 2013 through June 2014. The primary reason for using this method is that not all capitation payments were paid through the State's MMIS system in SFY 2014 and were instead paid on a gross adjustment basis (e.g. payments for retroactive rate adjustments). We were able to reconcile the estimated SFY 2014 capitation payments within 10% of the capitation payments paid through the MMIS system, and reconciled within 1% of the combined payments through the MMIS payments and the estimated payments made through a gross adjustment for the populations included in the waiver.**

**Because the SFY 2014 MCO capitation payments were estimated using the rates effective at the end of SFY 2014, all prospective capitation rate adjustments (included in state plan services trend adjustment) were developed in relation to the rates effective at the end of SFY 2014, and no further adjustment is needed to account for the capitation rates effective in the first quarter of SFY 2014 (July 2013 through September 2013).**

For Conversion or Renewal Waivers:

- a. \_\_\_\_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. \_\_\_\_ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- 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/R1 to P2: \_\_\_\_
- e. \_\_\_\_ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: \_\_\_\_\_.

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

For Initial Waivers:

- a. N/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.

**No exclusions. The managed care program encompasses many of the services provided to the individuals in this waiver. The Nurse Family Partnership program takes a holistic approach to managing an enrollee's health care. We expect all services utilized by this population to be impacted by the implementation of the waiver program, even those with low utilization for this population.**

**While we do not expect many individuals enrolled in an ICF/IID to be included in the waiver population given the targeted demographics, we did not exclude any individuals based on their level of care needed. While the utilization of certain services may be extremely low for this population (such as ICF/IID services), we believe the care coordination from the managed care program and Nurse Family Partnership program may impact the use of these services, and it is appropriate to include all services potentially provided in the waiver filing.**

For Conversion or Renewal Waivers:

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

\_\_\_\_\_

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

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

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

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart

below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

**For formatting purposes, estimated administrative costs associated with administration of the waiver and estimated state plan savings are illustrated with each waiver year in separate rows rather than all years combined into a single row. Trend rates are illustrated on the right. The PMPM and total expenditures are illustrated in separate tables.**

**Waiver Administrative Cost Compared with State Plan Savings – Total Expenditures  
State Fiscal Year 2014**

	<b>Additional Administrative Expenses</b>	<b>State Plan Savings</b>	<b>Inflation Projected</b>	<b>State Plan Trend</b>
<b>Year 1</b>	\$ 56,000	\$ 3,800,000	n/a	n/a
<b>Year 2</b>	58,000	5,800,000	2.2%	52.6%
<b>Year 3</b>	60,000	8,800,000	2.4%	51.7%
<b>Year 4</b>	62,000	11,900,000	2.4%	35.2%
<b>Year 5</b>	64,000	14,200,000	2.4%	19.3%
<b>Total</b>	\$ 300,000	\$ 44,500,000	n/a	n/a

Note: Administrative expenses illustrated reflect the estimated cost of SCDHHS administrative expenses necessary to administer the waiver.

**Waiver Administrative Cost Compared with State Plan Savings – PMPM Values  
State Fiscal Year 2014**

	<b>Additional Administrative Expenses PMPM</b>	<b>State Plan Savings PMPM</b>	<b>Inflation Projected</b>	<b>State Plan Trend</b>
<b>Year 1</b>	\$ 0.03	\$ 1.85	n/a	n/a
<b>Year 2</b>	0.03	2.84	2.2%	52.6%
<b>Year 3</b>	0.03	4.22	2.4%	51.7%
<b>Year 4</b>	0.03	5.67	2.4%	35.2%
<b>Year 5</b>	0.03	6.69	2.4%	19.3%
<b>Total</b>	\$ 0.03	\$ 4.28	n/a	n/a

Note: Administrative expenses illustrated reflect the estimated cost of SCDHHS administrative expenses necessary to administer the waiver.

**The above table illustrates the additional administrative costs associated with the administration of the waiver, which need to be offset by state plan savings. The additional administrative costs associated with the administration of the waiver were included in line 13, “Outstationed Eligibility Workers” in Appendix D2.A. The above**

table does not illustrate other historical administrative costs incorporated in Appendix D2.A.

The historical state fiscal year 2014 administrative costs summarized in Appendix D2.A were estimated on a level PMPM basis using total Medicaid population administrative costs from the CMS-64.10 divided by the total Medicaid population. The PMPM administrative cost was estimated in this way for each administrative service category. The PMPM amounts were then multiplied by the state fiscal year 2014 year membership for each MEG included in Appendix D to estimate the total base year administrative expenditures for the MEG.

The following exhibit reconciles the state plan savings expenditures illustrated above by comparing the state plan PMPM amounts from Appendix D5 under two different scenarios. In the first scenario, the state plan PMPMs are directly from the Appendix D5 workbook. In the second scenario, we developed the Appendix D5 state plan PMPMs after removing the state plan savings adjustments (columns S and T of Appendix D5). The difference in PMPMs under the two scenarios is the state plan PMPM savings. The state plan PMPM savings is multiplied by the member months to develop the state plan savings on a total expenditures basis. The highlighted cells reconcile to the state plan savings exhibit above.

### State Plan Savings by Prospective Year and Population

<b>Year 1</b>	<b>Member Months</b>	<b>PMPM With Savings Adjustments<sup>1</sup></b>	<b>PMPM Without Savings Adjustments<sup>2</sup></b>	<b>Difference</b>	<b>Total Savings</b>
LIF Females Ages 12-30	635,027	\$ 354.00	\$ 354.92	\$ (0.92)	\$ (580,000)
OCWI	389,497	919.77	922.45	(2.68)	(1,040,000)
Children 0-23 months	992,079	517.92	520.05	(2.13)	(2,110,000)
CHIP Children 0-23 months	16,552	157.97	159.19	(1.22)	(20,000)
<b>Total</b>	<b>2,033,155</b>	<b>540.78</b>	<b>542.63</b>	<b>(1.85)</b>	<b>(3,760,000)</b>
<b>Year 2</b>					
LIF Females Ages 12-30	640,805	\$ 372.72	\$ 373.73	\$ (1.01)	\$ (650,000)
OCWI	397,288	968.04	971.34	(3.30)	(1,310,000)
Children 0-23 months	999,302	543.78	547.61	(3.83)	(3,830,000)
CHIP Children 0-23 months	16,676	164.76	167.63	(2.87)	(50,000)
<b>Total</b>	<b>2,054,071</b>	<b>569.40</b>	<b>572.24</b>	<b>(2.84)</b>	<b>(5,830,000)</b>
<b>Year 3</b>					
LIF Females Ages 12-30	646,626	\$ 392.44	\$ 393.54	\$ (1.10)	\$ (710,000)
OCWI	405,233	1,018.73	1,022.82	(4.09)	(1,660,000)
Children 0-23 months	1,006,565	570.37	576.63	(6.26)	(6,300,000)
CHIP Children 0-23 months	16,801	171.27	176.51	(5.24)	(90,000)
<b>Total</b>	<b>2,075,225</b>	<b>599.25</b>	<b>603.47</b>	<b>(4.22)</b>	<b>(8,760,000)</b>
<b>Year 4</b>					
LIF Females Ages 12-30	652,499	\$ 413.20	\$ 414.40	\$ (1.20)	\$ (780,000)
OCWI	413,337	1,072.08	1,077.03	(4.95)	(2,050,000)
Children 0-23 months	1,013,880	598.38	607.19	(8.81)	(8,930,000)
CHIP Children 0-23 months	16,928	178.11	185.87	(7.76)	(130,000)
<b>Total</b>	<b>2,096,644</b>	<b>630.74</b>	<b>636.42</b>	<b>(5.68)</b>	<b>(11,910,000)</b>
<b>Year 5</b>					
LIF Females Ages 12-30	658,426	\$ 435.10	\$ 436.36	\$ (1.26)	\$ (830,000)
OCWI	421,605	1,128.68	1,134.11	(5.43)	(2,290,000)
Children 0-23 months	1,021,249	628.71	639.38	(10.67)	(10,900,000)
CHIP Children 0-23 months	17,056	186.17	195.72	(9.55)	(160,000)
<b>Total</b>	<b>2,118,336</b>	<b>664.48</b>	<b>671.17</b>	<b>(6.69)</b>	<b>(14,170,000)</b>
<b>Total</b>					
LIF Females Ages 12-30	3,233,383	\$ 393.86	\$ 394.96	\$ (1.10)	\$ (3,550,000)
OCWI	2,026,960	1,023.53	1,027.65	(4.12)	(8,350,000)
Children 0-23 months	5,033,075	572.23	578.60	(6.37)	(32,070,000)
CHIP Children 0-23 months	84,013	171.76	177.12	(5.36)	(450,000)
<b>Total</b>	<b>10,377,431</b>	<b>601.56</b>	<b>605.85</b>	<b>(4.28)</b>	<b>(44,430,000)</b>

**Notes**

1. PMPMs from Appendix D5, after the savings adjustments are applied.
2. PMPMs from Appendix D5, after removing the savings adjustments.

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

- a.  The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b.  The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c.  Other (Please explain).

**H. Appendix D3 – Actual Waiver Cost**

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

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

**For formatting purposes, estimated 1915(b)(3) costs and estimated state plan savings are illustrated with each waiver year in separates row rather than all years combined into a single row. Trend rates are illustrated on the right. The PMPM and total expenditures are illustrated in separate tables.**



**Waiver Service Cost Compared with State Plan Savings – Total Expenditures  
State Fiscal Year 2014**

	<b>1915(b)(3) Expenditures</b>	<b>State Plan Savings</b>	<b>1915 (b)(3) Trend</b>	<b>State Plan Savings Trend</b>
<b>Year 1</b>	\$ 2,500,000	\$ 3,800,000	n/a	n/a
<b>Year 2</b>	3,300,000	5,800,000	32.0%	52.6%
<b>Year 3</b>	3,900,000	8,800,000	18.2%	51.7%
<b>Year 4</b>	3,800,000	11,900,000	(2.6%)	35.2%
<b>Year 5</b>	1,300,000	14,200,000	(65.8%)	19.3%
<b>Total</b>	\$ 14,800,000	\$ 44,500,000	n/a	n/a

**Waiver Service Cost Compared with State Plan Savings – PMPM Values  
State Fiscal Year 2014**

	<b>1915(b)(3) Services PMPM</b>	<b>State Plan Savings PMPM</b>	<b>1915 (b)(3) Trend</b>	<b>State Plan Savings Trend</b>
<b>Year 1</b>	\$ 1.21	\$ 1.85	n/a	n/a
<b>Year 2</b>	1.59	2.84	32.0%	52.6%
<b>Year 3</b>	1.87	4.22	18.2%	51.7%
<b>Year 4</b>	1.82	5.67	(2.6%)	35.2%
<b>Year 5</b>	0.60	6.69	(65.8%)	19.3%
<b>Total</b>	\$ 1.42	\$ 4.28	n/a	n/a

**The first table illustrates the estimated total expenditure cost by waiver year for 1915(b)(3) services and additionally the estimated state plan savings on the same basis. The second table illustrates the total PMPM cost by the same stratification. The tables illustrate that the total state plan savings is estimated to be greater than the total 1915(b)(3) costs with the HV pilot project.**

**The 1915(b)(3) costs were estimated using the estimated enrollment in the HV pilot project, an estimated average of 24 total home visits per enrolled mother, and a per home visit cost of \$176.00. The number of enrolled mothers per year is illustrated below.**

Enrollment Per Year	
Year	Enrollment
Year 1	885
Year 2	661
Year 3	870
Year 4	784
Year 5	0
<b>Total</b>	<b>3,200</b>

**State plan savings from the HV pilot projected to offset additional 1915(b)(3) costs were estimated from a variety of sources. Definitions of each source of savings are provided below. Following the definitions, a table is provided that illustrates the assumptions used in estimating the savings from each source.**

1. **Reduction in Deliveries with Hypertension – Savings are estimated from the difference in the costs of a delivery with and without hypertension.**
2. **Reduction in Complicated Births – Savings are estimated from the difference in the birth costs (hospital and physician) of a normal newborn versus a newborn with complications.**
3. **Reduction in State Plan Postpartum Home Visits – Savings are estimated from the reduction in the utilization of the current state plan postpartum home visits. Since the beneficiary will not be receiving the State Plan postpartum home visits, the cost of those visits is avoided, thus resulting in an offsetting savings. The estimated savings is \$193.28 per enrolled mother, which reflects a reduction of two home visits at a rate of \$96.64 each.**
4. **Reduction in Child Ages 0-2 Expenditures from Complicated Birth – Savings are estimated from the difference in medical expenditures during the first two years of life, excluding birth related expenditures, between a normal newborn and a newborn born with complications.**
5. **Reduction in Ages 0-2 Child Hospitalization – Savings are estimated from a reduction in hospital expenditures for the first two years of life, excluding the inpatient expenditures in year one which may be birth related expenditures.**

**Assumptions used in Estimating Savings by Source**

<b>Reductions</b>	<b>Hypertension</b>	<b>Complicated Births</b>	<b>State Plan Postpartum visits</b>	<b>Child Ages 0-2 Expenditures from Complicated birth</b>	<b>0-2 Child Hospitalizations</b>
<b>Estimated Savings Per Event</b>	\$3,877.00	\$22,432.00	\$193.28	\$4,836.44	\$756.24
<b>Estimated Savings Base Year</b>	2012	2011	2016	2012	2012
<b>Estimated Savings Trended to CY 2016<sup>1</sup></b>	\$4,448.95	\$26,642.18	\$193.28	\$5,549.92	\$867.80
<b>Prevalence</b>	8.5%	18.1%	100.0%	18.1%	100.0%
<b>Reduction</b>	27.0%	28.0%	100.0%	28.0%	38.0%
<b>Estimated Savings Per Participant Per Year</b>	\$102.59	\$1,350.23	\$193.28	\$281.27	\$329.77
<b>Years of Impact</b>	1	1	1	2	2
<b>Mothers/Child</b>	Mother	Child	Mother	Child	Child

**Notes**

1. CY 2016 savings were estimated using a 3.5% medical trend rate.
2. The reductions illustrated above were only applied to the estimated number of HV participants.

**As a part of the Enhanced Prenatal and Postpartum Home Visitation Pilot Project Waiver, we are projecting to manage the state plan services of the included populations at a 0.25% lower trend rate than would have otherwise been experienced. This adjustment was explicitly included in Appendix D5; it was not an implicit reduction to the trend used in trending state plan services.**

**The following two tables provide a high level reconciliation between the savings assumptions illustrated above and the NFP savings adjustment used in Appendix D5. The first exhibit provides a high level calculation of the estimated savings from the NFP program over the 5 year waiver period. The estimate was developed by multiplying the estimated savings for each mother and child participant by the number of estimated participants in the program.**

**High Level Nurse Family Partnership Savings  
Over the Full 5 Year Wavier Period**

	<u>Savings Per Year</u>	<u>Years of Impact</u>	<u>Total Savings Per Participant</u>
Hypertension <sup>1</sup>	\$ 102.59	1	\$ 102.59
Complicated Births <sup>1</sup>	1,350.23	1	1,350.23
State Plan Postpartum Visits <sup>1</sup>	193.28	1	193.28
Child Ages 0-2 Expenditures from Complicated Birth <sup>1</sup>	281.27	2	562.54
0-2 Child Hospitalizations <sup>1</sup>	329.77	2	659.54
Total Savings per Participant <sup>2</sup>			\$ 2,868.18
Number of Particants <sup>2</sup>			3,200
Total Savings (Non-cumulative) <sup>3</sup>			\$ 9,200,000

**Notes**

1. Values are illustrated in the assumption exhibit in the table “Assumptions used in Estimating Savings by Source”.
2. For purposes of this exhibit, one participant includes both the mother and the child enrolled in the program.
3. Savings illustrated are non-cumulative, meaning no calculation was performed to estimate the effect of the savings on following years. Within the Appendix D workbook, a reduction in state plan in one year effects the estimated state plan expenditures in all the following years.

**The corresponding exhibit below illustrates the savings attributable to the NFP program using values directly from the Appendix D workbook. The exhibit uses member months from Appendix D1 and the state plan PMPM from Appendix D5 to estimate total state plan expenditures by year and MEG. The NFP savings percentage from Appendix D5 is then multiplied by the total expenditures to estimate the state plan savings. The highlighted number in the exhibit illustrates the 5 year total estimated savings. Please note that for this reconciliation the savings illustrated are not cumulative, even though a savings in one year affects the estimated state plan PMPM in the following years within the Appendix D workbook.**

**Estimated Nurse Family Partnership Savings from Appendix D5**

<b>Year 1</b>	<b>Member Months</b>	<b>State Plan PMPM<sup>1</sup></b>	<b>State Plan Expenditures</b>	<b>State Plan Savings %</b>	<b>State Plan Savings Expenditures</b>
LIF Females Ages 12-30	635,027	\$ 354.92	\$ 225,380,000	(0.01%)	\$ (20,000)
OCWI	389,497	922.45	359,290,000	(0.04%)	(140,000)
Children 0-23 months	992,079	520.05	515,930,000	(0.16%)	(830,000)
CHIP Children 0-23 months	16,552	159.19	2,630,000	(0.52%)	(10,000)
<b>Total</b>	<b>2,033,155</b>	<b>542.63</b>	<b>1,103,250,000</b>	<b>(0.09%)</b>	<b>(1,000,000)</b>
<b>Year 2</b>					
LIF Females Ages 12-30	640,805	\$ 372.76	\$ 238,870,000	(0.01%)	\$ (20,000)
OCWI	397,288	968.52	384,780,000	(0.05%)	(190,000)
Children 0-23 months	999,302	545.37	544,990,000	(0.29%)	(1,580,000)
CHIP Children 0-23 months	16,676	166.34	2,770,000	(0.95%)	(30,000)
<b>Total</b>	<b>2,054,071</b>	<b>570.29</b>	<b>1,171,420,000</b>	<b>(0.16%)</b>	<b>(1,820,000)</b>
<b>Year 3</b>					
LIF Females Ages 12-30	646,626	\$ 392.48	\$ 253,790,000	(0.01%)	\$ (30,000)
OCWI	405,233	1,019.34	413,070,000	(0.06%)	(250,000)
Children 0-23 months	1,006,565	572.61	576,370,000	(0.39%)	(2,250,000)
CHIP Children 0-23 months	16,801	173.49	2,910,000	(1.28%)	(40,000)
<b>Total</b>	<b>2,075,225</b>	<b>600.49</b>	<b>1,246,150,000</b>	<b>(0.21%)</b>	<b>(2,570,000)</b>
<b>Year 4</b>					
LIF Females Ages 12-30	652,499	\$ 413.24	\$ 269,640,000	(0.01%)	\$ (30,000)
OCWI	413,337	1,072.72	443,390,000	(0.06%)	(270,000)
Children 0-23 months	1,013,880	600.60	608,940,000	(0.37%)	(2,250,000)
CHIP Children 0-23 months	16,928	180.35	3,050,000	(1.24%)	(40,000)
<b>Total</b>	<b>2,096,644</b>	<b>631.97</b>	<b>1,325,020,000</b>	<b>(0.20%)</b>	<b>(2,590,000)</b>
<b>Year 5</b>					
LIF Females Ages 12-30	658,426	\$ 435.10	\$ 286,480,000	0.00%	\$ 0
OCWI	421,605	1,128.90	475,950,000	(0.02%)	(100,000)
Children 0-23 months	1,021,249	630.09	643,480,000	(0.22%)	(1,420,000)
CHIP Children 0-23 months	17,056	187.55	3,200,000	(0.74%)	(20,000)
<b>Total</b>	<b>2,118,336</b>	<b>665.20</b>	<b>1,409,120,000</b>	<b>(0.11%)</b>	<b>(1,540,000)</b>
<b>Total</b>					
LIF Females Ages 12-30	3,230,000	\$ 394.48	\$ 1,274,160,000	(0.01%)	\$ (100,000)
OCWI	2,030,000	1,022.90	2,076,480,000	(0.05%)	(950,000)
Children 0-23 months	5,030,000	574.49	2,889,710,000	(0.29%)	(8,330,000)
CHIP Children 0-23 months	80,000	182.19	14,560,000	(0.96%)	(140,000)
<b>Total</b>	<b>10,380,000</b>	<b>602.60</b>	<b>6,254,960,000</b>	<b>(0.15%)</b>	<b>(9,520,000)</b>

**Notes**

**1. PMPMs from Appendix D5, before the savings adjustments are applied.**

The savings estimates used in Appendix D5 were developed using a monthly enrollment schedule and a monthly savings schedule which aligns the savings with the month they are expected to occur. For example, savings from avoiding a hypertensive birth are estimated to occur at the time of delivery. Therefore, an exhibit directly cross-walking the savings assumptions to the estimated savings illustrated in Appendix D5 is not possible. We have provided the above high level reconciliation to illustrate the reasonability of the results included in the Appendix D5 workbook. The highlighted values reconcile within 3.5%. Differences in the NFP savings estimates illustrated in the two exhibits are attributable to the interaction of other adjustments in Appendix D5 (such as trend rates, program adjustments, and other savings adjustments) and timing differences in the savings amounts.

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

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

<b>1915(b)(3) Service</b>	<b>Amount Spent in Retrospective Period</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
<b>Total</b>	<u>N/A</u>		<u>N/A</u>

- b. N/A 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. N/A 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. \_\_\_ 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. N/A Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. \_\_\_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
  - i. Document the criteria for awarding the incentive payments.
  - ii. Document the method for calculating incentives/bonuses, and
  - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
2. \_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM

providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)

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

### **Current Initial Waiver Adjustments in the preprint**

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

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. \_\_\_ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:



2. X [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
- i. \_\_\_\_\_ State historical cost increases. Please indicate the years on which the rates are based: base years \_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
- ii. X 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.

**For state plan services trend, fee-for-service expenditures were trended at the president's budget trend for Section 1931 adults, which is representative of the low income families included in this waiver demonstration. Capitation payments were trended using known capitation rate changes effective July 1, 2014 and January 1, 2015. Following the known changes, capitation rates were assumed to increase by the president's budget trend for Section 1931 adults on July 1 of each year, consistent with the current capitation rate setting cycle.**

**The following table illustrates the historical PMPM trends by population over the most recent three completed state fiscal years.**

**Per Member Per Month Costs by Population and State Fiscal Year  
On a Paid Basis**

<b>Population</b>	<b>SFY 2013</b>	<b>Growth</b>	<b>SFY 2014</b>	<b>Growth</b>	<b>SFY 2015</b>
LIF Adults	\$ 394.52	5.0%	\$ 414.14	6.3%	\$ 440.25
Pregnant Women	845.04	3.3%	872.85	1.9%	889.45
CHIP Children	153.86	3.0%	158.50	7.6%	170.54
All Other Children	211.67	6.0%	224.37	10.1%	246.92
Disabled Adults and Elderly	1,019.73	6.8%	1,088.74	8.7%	1,183.52
Composite - Total	\$ 418.82	4.4%	\$ 437.13	4.5%	\$ 456.77

**Notes**

- a. PMPMs are illustrated on a paid basis and are a combination of fee-for-service and MCO experience.
- b. Children populations include children up to age 18.
- c. The disabled adults and elderly populations are not included in the waiver; they are included for completeness of illustrating SCDHHS PMPM trends for full benefit eligible individuals.

**The table is a compilation of exhibits provided to SCDHHS for their budget forecast and is based on historical enrollment and expenditure data on a paid basis. The PMPM amounts reflected in the table are a combination of both MCO and fee-for-service experience.**

**The table illustrates the volatility of the PMPM trends on a population basis. These trends are impacted by program and policy changes as well as medical inflation. Given the volatility of the historical trend rates, we believe it is reasonable to use a stable prospective trend rate. Therefore, we have utilized the president's budget trend.**

**Adjustments for known program changes, administrative cost trends, and 1915(b)(3) trends are separately accounted for in Section D.I.b., D.I.c and D.I.d, respectively.**

3. \_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.
  - i. Please indicate the years on which the utilization rate was based (if calculated separately only).

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

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

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

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

2. X 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. 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):

**SCDHHS has implemented multiple hospital rate increase and hospital rate normalizations between the start of the base year (SFY 2014) and prospective year 1 (CY 2016). SCDHHS implemented a 2.75% hospital rate increase effective 10/1/2013 and a 2.5% hospital rate increase effective 10/1/2014. Additionally, SCDHHS reduced the range of conversion factors used in the calculation of hospital reimbursement effective 7/1/14 and intends to reduce the range further effective 10/1/15. Adjustment factors were estimated to quantify the effect of the hospital rate increases and conversion factor rate normalizations.**

c. X **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. X An administrative adjustment was made.
  - i. \_\_\_ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. \_\_\_ Other (please describe):
  - ii. X 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. X Other (please describe):  
**The estimate in the congressional budget office’s report “The Budget and Economic Outlook: 2014 to 2024” of the Consumer Price Index increases over the waiver projection time period was used to estimate the PMPM administrative cost increase.**
  - iii. \_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
    - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase.
    - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
1. **X** [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: **Varies by projection year.** Please provide documentation.
- The 1915b(3) costs in P1 were estimated using the total estimated 1915(b)(3) expenditures using the estimated enrollment in the HV pilot project, an estimated average of 24 total home visits per enrolled mother, and a per home visit cost of \$176.00. The number of enrolled mothers per year is illustrated below.**

Enrollment Per Year	
Year	Enrollment
Year 1	885
Year 2	661
Year 3	870
Year 4	784
Year 5	0
<b>Total</b>	<b>3,200</b>

**1915(b)(3) service trends for P1 and on were estimated using the total estimated expenditures on 1915(b)(3) services in each waiver year. The estimated 1915(b)(3) expenditures were estimated by multiplying the estimated cost per participant per month by the expected enrollment schedule. Therefore, 1915(b)(3) trends are significantly impacted by the HV program participant enrollment schedule, and therefore are sometimes significantly higher than the state plan service trends when the costs are spread over the entire waiver population included in the Appendix D workbook.**

**The following table compares the state plan and 1915(b)(3) service trend over the waiver period:**

**State Plan and 1915(b)(3) PMPMs by Year**

	State Plan PMPM	State Plan Annual Trend	1915(b)(3) PMPM	1915(b)(3) Annual Trend
Year 1	\$545.76	N/A	\$ 1.23	N/A
Year 2	573.76	5.1%	1.62	31.7%
Year 3	602.89	5.1%	1.89	16.5%
Year 4	633.56	5.1%	1.83	(3.3%)
Year 5	666.38	5.2%	0.61	(66.5%)
<b>Annualized P1 to P5 Trend</b>	N/A	5.1%	N/A	(16.0%)

2. \_\_\_ [Required, when the State’s BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State’s trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a.** N/A

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** N/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. X We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

**GME payments are not included in the inpatient portion of the capitation payments made for MCO enrollees. GME related to outpatient services is embedded in the outpatient multipliers, which is included in the capitation payments made for MCO enrollees. GME payments are also included in the fee-for-service claims data. Therefore, an adjustment was made to include inpatient GME for MCO enrollees only, because all other GME payments are included in the base data.**

**Inpatient GME payments attributable to MCO enrollees are paid through a gross adjustment. GME payments were estimated for the populations included in the waiver by estimating a level GME PMPM**

**amount for all MCO enrollees, which was then multiplied by the MCO enrollees in the base year. The estimated GME amount is included in tab “D3. Actual Waiver Cost” MCO/PIHP capitated cost column.**

3. \_\_\_ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. \_\_\_ GME adjustment was made.
  - i. \_\_\_ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  - ii. \_\_\_ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. **X** 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. **X** The State had no recoupments/payments outside of the MMIS.
- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
- Basis and Method:*
1. \_\_\_ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.



2. \_\_\_ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.  The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. \_\_\_ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.  No adjustment was necessary and no change is anticipated.
2. \_\_\_ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

*Method:*

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

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

*Basis and method:*

1.  No adjustment was necessary
2. \_\_\_ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. \_\_\_ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. \_\_\_ The State made this adjustment:
  - i. \_\_\_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
  - ii. \_\_\_ Other (please describe):

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

*Basis and Method:*

1. \_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
  2. \_\_\_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
  3. X Other (please describe):  
**We did not allocate any of the FFS pharmacy rebates or MCO national agreement pharmacy rebates to this program due to the small component of pharmacy expenditures.**
- 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. X 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.  
**The cost effectiveness workbook includes all individuals enrolled in a managed care organization and individuals receiving services on a fee-for-service basis impacted by the waiver. The entire Nurse Family Partnership eligible population is included in the cost-effectiveness calculation. Additionally, populations included in the waiver are currently mandatorily enrolled in managed care through 1932(a) authority. Because the full**

**population is included and this population has already been transitioned to managed care, no selection adjustment is needed.**

2. \_\_\_ This adjustment was made:

- a. \_\_\_ Potential Selection bias was measured in the following manner:
- b. \_\_\_ The base year costs were adjusted in the following manner:

- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
  - 1. **X** We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
  - 2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
  - 3. \_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
  - 4. \_\_\_ Other (please describe):

**Special Note section:**

**Waiver Cost Projection Reporting: Special note for new capitated programs:**

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. \_\_\_ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. \_\_\_ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**

**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations** -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.**

When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (\*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: $\text{PMPM Waiver Cost Projection} - \text{PMPM Actual Waiver Cost} = \text{PMPM Cost-effectiveness}.$ )

- 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. X 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. X This adjustment is not necessary as this is not an initial PCCM waiver in the

waiver program.

2. \_\_\_ This adjustment was made in the following manner:

- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. X No adjustment was made.
  2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

**J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.**

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases

in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. \_\_\_\_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:
2. \_\_\_\_ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
  - i. \_\_\_\_ State historical cost increases. Please indicate the years on which the rates are based: base years \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
  - ii. \_\_\_\_ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used \_\_\_\_\_. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. \_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
  - i. Please indicate the years on which the utilization rate was based (if calculated separately only).
  - ii. Please document how the utilization did not duplicate separate cost increase trends.

b. \_\_\_\_ **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. \_\_\_\_ 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. \_\_\_ 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:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews,



etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. \_\_\_ No adjustment was necessary and no change is anticipated.
2. \_\_\_ An administrative adjustment was made.
  - i. \_\_\_ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
  - ii. \_\_\_ Cost increases were accounted for.
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. \_\_\_ State Historical State Administrative Inflation. The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:
    - D. \_\_\_ Other (please describe):
  - iii. \_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
    - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
    - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the

R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. \_\_\_\_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e.*, *trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
2. \_\_\_\_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e.*, *trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
  - i. State historical 1915(b)(3) trend rates
    1. Please indicate the years on which the rates are based: base years \_\_\_\_\_
    2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
  - ii. State Plan Service Trend
    1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.

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

1. List the State Plan trend rate by MEG from **Section D.I.J.a** \_\_\_\_\_
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** \_\_\_\_\_
3. Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services

were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)\*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.  
*Basis and Method:*

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

**For state plan services trend, fee-for-service expenditures were trended at the president's budget trend for Section 1931 adults, which is representative of the low income families included in this waiver demonstration. Capitation payments were trended using known capitation rate changes effective July 1, 2014 and January 1, 2015. Following the known changes, capitation rates were assumed to increase by the president's budget trend for Section 1931 adults on July 1 of each year, consistent with the current capitation rate setting cycle.**

**SCDHHS has implemented multiple hospital rate increase and hospital rate normalizations between the start of the base year (SFY 2014) and prospective year 1 (CY 2016). SCDHHS implemented a 2.75% hospital rate increase effective 10/1/2013 and a 2.5% hospital rate increase effective 10/1/2014. Additionally, SCDHHS reduced the range of conversion factors used in the calculation of hospital reimbursement effective 7/1/14 and intends to reduce the range further effective**

**10/1/15. Adjustment factors were estimated to quantify the effect of the hospital rate increases and conversion factor rate normalizations.**

**The estimate in the congressional budget office’s report “The Budget and Economic Outlook: 2014 to 2024” of the consumer price index increases over the waiver projection time period was used to estimate the PMPM administrative cost increase.**

**State plan savings from the HV pilot projected to offset additional 1915(b)(3) costs were estimated from a variety of sources. Savings estimates include a reduction in expenditures attributable to deliveries with hypertension, a reduction in complicated births, reductions in state plan postpartum home visits, a reduction in child ages 0-2 expenditures from complicated births, and a reduction in ages 0-2 child hospitalization. These savings are further described in Section D.H. Additionally, we are projecting to manage the state plan services of the included populations at a 0.25% lower trend rate than would have otherwise been experienced. This adjustment was explicitly included in Appendix D5; it was not an implicit reduction to the president’s budget trend used in trending state plan services.**

**1915(b)(3) service trends were estimated using the actual estimated expenditures on 1915(b)(3) services in each waiver year. The estimated 1915(b)(3) expenditures were estimated by multiplying the estimated cost per participant (based on 24 total home visits per enrolled mother and a per visit cost of \$176) per month by the expected enrollment schedule. Therefore, 1915(b)(3) trends are significantly impacted by the HV program participant enrollment schedule.**

**The following table compares the state plan and 1915(b)(3) service trend over the waiver period:**

**State Plan and 1915(b)(3) PMPMs by Year**

	State Plan PMPM	State Plan Annual Trend	1915(b)(3) PMPM	1915(b)(3) Annual Trend
Year 1	\$545.76	N/A	\$ 1.23	N/A
Year 2	573.76	5.1%	1.62	31.7%
Year 3	602.89	5.1%	1.89	16.5%
Year 4	633.56	5.1%	1.83	(3.3%)
Year 5	666.38	5.2%	0.61	(66.5%)
Annualized P1 to P5 Trend	N/A	5.1%	N/A	(16.0%)

**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.

**Enrollment trends are consistent with trends estimated in the state of South Carolina's Medicaid Assistance Forecast. These trends are estimated based on historical enrollment data and discussions with SCDHHS personnel.**

**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 caseload change contributes to an estimated 0.3% annualized composite PMPM decrease from the base year to prospective year one. Caseload changes after year one result in a less than an estimated 0.1% annualized PMPM change.**

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

**Unit cost changes are reflected in the state plan services trend adjustment and programmatic adjustment for the hospital rate increase and hospital conversion factor normalization adjustments described in section D.I.b. Administrative unit cost increases were estimated based on the congressional budget office's estimate of future Consumer Price Index increases.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

**Utilization changes are reflected in the state plan services trend adjustment.**

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.