Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Texas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
MTO NEMT	MTO Nonemergency Medical Transportation	PAHP;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
MTO NEMT

C. Type of Request. This is an:

☑ **Amendment request for an existing waiver.**
The amendment modifies (Sect/Part):
Section A Part I, Part 1 Section C, Part I Section D

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ○ **2 years** ○ **3 years** ○ **4 years** ◉ **5 years**

Draft ID:TX.079.01.01
Waiver Number:TX.0024.R01.01

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)
Approved Effective Date of Base Waiver being Amended: 04/01/17
Proposed Effective Date: *(mm/dd/yy)*
09/01/17
Approved Effective Date: 10/04/17

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Kathi Montalbano **Phone:** (512) 730-7409 **Ext:** ☐ **TTY**

Fax: (512) 487-3403 **E-mail:** kathi.montalbano@hhsc.s

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **MTO Nonemergency Medical Transportation**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

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.
HHSC has signed an agreement with the state's federally recognized tribes and tribal organizations describing the tribal consultation process. The agreement requires a request for feedback for waiver changes that have an impact on (1) client eligibility, (2) acute care services and (3) acute care providers. NEMT is not an acute care service and this amendment has no impact on client eligibility. In the interest of open communication with the tribes, however, HHSC sent a notification of the amendment and request for feedback to the tribes and tribal organizations on July 13, 2017.

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 Nonemergency Medical Transportation (NEMT) waiver began on April 1, 2011 as a fee-for-service waiver and it allowed the state the flexibility to arrange for and assure necessary, cost effective NEMT in specific areas of the state.

On September 1, 2014, the state changed from a fee-for-service waiver to a capitated rate system in eleven (11) regions of the State. The MTO is required to deliver all NEMT services under a full risk model through a capitated rate system. MTOs replaced the then existing Transportation Service Area Providers (TSAPs) and provided transportation services in newly designated MTO Regions. Full Risk Brokers (FRBs) continued to deliver NEMT services in their previously defined Service Delivery Areas. MTOs are defined as:
- Rural or urban transit district;
- Public Transportation provider;
- Regional contracted broker;
- Local private transportation provider; or
- Any other entity the commission determines meets the requirements.

The MTOs provide the same level of transportation services as the Full Risk Brokers. MTOs must meet the following additional requirements:
- Operate under a capitated rate system;
- Assume financial responsibility under a full risk model;
- Operate a call center;
- Use fixed routes when available and appropriate;
- Agree to provide data to HHSC as determined by HHSC;
- Attempt to contract with providers that are considered significant traditional providers,
- Meet the minimum quality and efficiency measures determined by HHSC, and
- Agree to accept the prevailing contract rate of the MTO.

Pursuant to state law, MTOs may own, operate and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles.

The MTO is required to ensure that transportation services are available and provided to all clients in its MTO Region. During the period September 1, 2014 through May 31, 2015, this waiver covered 110 of the 254 Texas Counties and five of the 11 MTO Regions: Regions 1, 2, 4, 8, and 10.

On June 1, 2015, Region 8 was moved from this waiver to the State Plan, and on August 1, 2016, Region 4 was moved from this waiver to its own 1915(b)(4) waiver.

The purpose of this 1915(b) waiver amendment is to remove Regions 1 and 10 from the waiver effective September 1, 2017. The current contract with LeFleur, the contractor in Regions 1 and 10, expires on August 31, 2017. Effective September 1, 2017, services in Regions 1 and 10 will be provided under the State Plan.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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.
-- *Specify Program Instance(s) applicable to this authority*
☑ **MTO NEMT**

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.
-- *Specify Program Instance(s) applicable to this authority*
☐ **MTO NEMT**

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.
-- *Specify Program Instance(s) applicable to this authority*
☐ **MTO NEMT**

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).
-- *Specify Program Instance(s) applicable to this authority*
☑ **MTO NEMT**

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:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

a. ☑ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- *Specify Program Instance(s) applicable to this statute*
☑ **MTO NEMT**

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

☑ **MTO NEMT**

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

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). CMS Regional Office has directed the State to identify a Managed Transportation Organization (MTO) as a prepaid ambulatory health plan (PAHP). MTOs provide only Nonemergency Medical Transportation (NEMT) services. Furthermore, MTOs must, by contract, serve all clients in its MTO Region and therefore have neither enrollees, nor potential enrollees. Wherever this application refers to an enrollee, the State will interpret that term to mean a client in an MTO Region.
-- *Specify Program Instance(s) applicable to this statute*
☑ **MTO NEMT**

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.

-- *Specify Program Instance(s) applicable to this statute*
☐ **MTO NEMT**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

○ **The PIHP is paid on a risk basis**
○ **The PIHP is paid on a non-risk basis**

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

- ◉ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

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

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

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

Nonemergency Medical Transportation (NEMT). On September 1, 2014, Texas introduced a Managed Transportation Organization Delivery Model that utilizes Managed Transportation Organizations (MTOs) to provide efficient and cost effective transportation services to eligible clients in designated regions. MTOs replaced the existing Transportation Service Area Providers (TSAPs) and provide transportation services in designated MTO Regions and Full Risk Brokers (FRBs)offer transportation services in their previously defined Service Delivery Areas. MTOs are defined as:
- Rural or urban transit district;
- Public Transportation provider;
- Regional contracted broker;
- Local private transportation provider; or
- Any other entity the commission determines meets the requirements.

The MTOs provide the same level of transportation services as Full Risk Brokers. MTOs must meet the following additional requirements:
- Operate under a capitated rate system;
- Assume financial responsibility under a full risk model;
- Operate a call center;
- Use fixed routes when available and appropriate;
- Agree to provide data to HHSC as determined by HHSC;
- Attempt to contract with providers that are considered significant traditional providers,
- Meet the minimum quality and efficiency measures determined by HHSC, and
- Agree to accept the prevailing contract rate of the MTO.

Pursuant to state law, MTOs may own, operate and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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):

- ☐ **Procurement for MCO**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- ☐ **Procurement for PIHP**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- ☑ **Procurement for PAHP**
  - ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- ☐ **Procurement for PCCM**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)
- ☐ **Procurement for FFS**
  - ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
  - ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
  - ○ **Sole source** procurement
  - ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
MTOs are responsible for arranging and administering cost-effective NEMT services to eligible Medicaid beneficiaries who have no other means of transportation.

MTOs Primary Functions
- Operate call centers
- Manage provider network and monitor network providers
- Provide all NEMT services to eligible clients in their MTO Region
- Ensure all NEMT services provided by the MTO are prior authorized
- Manage client and provider reimbursements for transportation services

Transportation Services include:
- Mass Transit - Fixed route, intercity, or intracity transportation systems.
- Airline Transportation - service provided by a commercial airline for medical care that can't be provided in the client's service area.
- Demand Response - Transportation that involves using contractor dispatched vehicles in response to requests from individual or shared one-way trips.
- Mileage Reimbursement - Individual Transportation Participant (ITPs) - reimbursement to a family member, friend or neighbor to drive a client to a health care service.
- Advanced Funds - funds authorized by the MTO in advance of travel and provided to the client or attendant to cover authorized transportation services for travel to a medically necessary health care service.
- Meals/Lodging - provided for overnight or extended stays.

MTOs receive capitation payments to provide all NEMT services to eligible clients in a specific geographic area of the state.

Payment methodology is capitated - per member, per month.

Contracts were procured through a competitive procurement process.

The State does not directly reimburse performing providers for transportation services, including individual transportation participants; the State pays a fixed monthly capitation rate to the MTO. While the State monitors MTOs to minimize inappropriate payments by MTOs, any inappropriate payment is at the MTO's expense. The MTOs may not add in costs for "no shows" or "non-loaded trips" into its calculation for administrative or operational expenses. These trips are considered an unallowable cost, should be excluded from the MTO's Financial Statistical Report (FSR), and are not used to calculate the capitated rate.

The MTO only reimburses Individual Transportation Participants (ITPs) for transportation to and from a Medicaid-covered service; ITPs should not receive reimbursement for mileage incurred when the client is not in the vehicle (i.e., "unloaded miles" or "non-loaded trips").

The State addresses the issue of no-shows through its quarterly review of matched transportation claims and an associated healthcare event. Transportation providers must submit driver logs to support questionable claims. If the transportation provider cannot validate the claim for payment, the MTO should not pay the provider.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

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 1932(a)(3) 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.

42 CFR 438.52 does not apply to NEMT PAHPs, effective July 2016.

The State will contract with one MTO per MTO Region. This service delivery model is not detrimental to the clients' ability to access transportation services. The MTO is required to ensure that transportation services are available and provided to all clients in its MTO Region. During the period September 1, 2014 through May 31, 2015, this waiver covered 110 of the 254 Texas Counties and five of the 11 MTO Regions. Effective June 1, 2015, Region 8 was removed from this waiver to the State Plan and effective August 1, 2016, Region 4 was removed from this waiver to its own 1915(b)(4) waiver. Effective September 1, 2017, Regions 1 and 10 are being removed from this waiver to the State Plan.

The MTO performs administrative functions to ensure reliable transportation for both ambulatory and nonambulatory clients to and from healthcare services appointments. The MTO must ensure the availability of a sufficient and reliable fleet of vehicles, as well as qualified drivers, to meet the transportation service requirements under its contract with the State.

The State further provides adequate safeguards and monitoring to ensure that MTOs meet their contractual obligations.

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

Program: " **MTO Nonemergency Medical Transportation.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☐ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☑ **Other:**

please describe

HHSC offers clients NEMT services through MTOs to meet the client's transportation needs. The appropriate means of transportation is based on several factors, including client's healthcare needs, availability of service, travel distance, and cost of services.

Each client is automatically enrolled with the MTO responsible for providing NEMT services in the MTO Region in which the client resides.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

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.

Managed Transportation Organization Regions: Geographic area served by a specific MTO. The MTO is selected through a competitive procurement process.

○ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

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
     -- *Specify Program Instance(s) for Statewide*
     ☐ **MTO NEMT**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     ☑ **MTO NEMT**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Ward, Winkler	PAHP	Competitive Procurement
Pecos, Presidio	PAHP	Competitive Procurement
Jeff Davis	PAHP	Competitive Procurement
Ector, El Paso	PAHP	Competitive Procurement
Loving	PAHP	Competitive Procurement
Terrell, Upton	PAHP	Competitive Procurement
Dawson	PAHP	Competitive Procurement
Howard, Hudspeth	PAHP	Competitive Procurement
Reeves	PAHP	Competitive Procurement
Borden, Brewster	PAHP	Competitive Procurement
Andrews	PAHP	Competitive Procurement
Martin, Midland	PAHP	Competitive Procurement
Gaines, Glasscock	PAHP	Competitive Procurement
Crane, Culberson	PAHP	Competitive Procurement

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:
The counties listed are divided into Managed Transportation Organization Regions. Here is the breakdown of each Managed Transportation Organization Region and included counties.

MTO 2: (Project Amistad) Andrews, Borden, Brewster, Crane, Culberson, Dawson, Ector, El Paso, Gaines, Glasscock, Howard, Hudspeth, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reeves, Terrell, Upton, Ward, Winkler.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

- [x] **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
  - (•) **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**
  - ( ) **Voluntary enrollment**

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

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Other** (Please define):

Nursing facility residents may obtain NEMT services to/from dialysis treatment as a waiver benefit.

All Medicaid-eligible individuals under the age of 21 may obtain NEMT services, including transportation to EPSDT services.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

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

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

☑ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

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

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

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

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

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

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

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

☑ **Other** (Please define):
Exclude nursing facility and ICF/IID residents, except for nursing facility residents needing NEMT to/from dialysis treatment.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
No additional information added.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. **Assurances.**

☐ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

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

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

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

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

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:
- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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.

   Emergency Services Category General Comments (optional):

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.

   Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

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

☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

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

FQHC Services Category General Comments (optional):

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.

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

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.

1915(b)(3) Services Requirements Category General Comments:

7. **Self-referrals.**

☐ 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:

Self-referrals Requirements Category General Comments:

8. **Other.**

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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.

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   a. ☐ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

   d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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.
   Not applicable.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:
This 1915(b)(4) waiver program does not include a PCCM component.

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

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

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

   ☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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:

   42 CFR 438.207 does not apply to NEMT PAHPs, effective July 2016.

   ☑ 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.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☐ The State has set **enrollment limits** for each PCCM primary care provider.

     Please describe the enrollment limits and how each is determined:

   - **b.** ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

     Please describe the State's standard:

   - **c.** ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

     Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)
   - **d.** ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

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

   - **e.** ☐ The State ensures adequate **geographic distribution** of PCCMs.

     Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)
   - **f.** ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

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

     Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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.
   Not applicable.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
This 1915(b)(4) waiver program does not include a PCCM component.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

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.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

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

The following items are required.

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

Please provide justification for this determination:

According to 42 CFR 438.9, NEMT PAHPS are not required to comply with 42 CFR 438.208 Availability of Services.

b. ☐ **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:

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:

Please describe the enrollment limits and how each is determined:

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.

Please describe:

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.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **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.** ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   - **b.** ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   - **c.** ☐ Each enrollee is receives **health education/promotion** information.

     Please explain:
   - **d.** ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   - **e.** ☐ There is appropriate and confidential **exchange of information** among providers.
   - **f.** ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
   - **g.** ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   - **h.** ☐ **Additional case management** is provided.

     Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.
   - **i.** ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

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.
   Contract requirements encourage MTOs to coordinate with licensed, qualified, and competent transportation providers. Maintaining this model allows HHSC to continue to use and encourage coordination with local service delivery providers to include local transit authorities and cab companies. This service delivery model supports the use of direct service delivery providers and existing networks of transportation providers. To ensure that client transportation needs are met, this model offers flexibility to the MTOs for scheduling demand response services through subcontacting transportation services, direct service delivery, and use of alternative transportation service providers to fill in gaps in service delivery. This approach offers an efficient and effective model for meeting clients' transportation needs.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
Section A (Part II)(C)(2)(a-e)(3)(a-i) Not applicable.

Section A: Program Description

Part III: Quality

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

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

☐ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on: *(mm/dd/yy)*

☐ 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 Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

Section A: Program Description

Part III: Quality

2. **Assurances For PAHP program**

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

☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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:

This waiver is for Nonemergency Medical Transportation services.
Section 438.210 largely relates to the scope of health care services, not transportation services. The MTO contract describes the scope of transportation services to be offered.
Section 438.214 - MTOs may implement written policies and procedures for selection and retention of transportation providers, but "credentialing" and "recredentialing" are not applicable.
438.218 - This provision no longer exists.
438.226 - This provision does not apply to NEMT PAHPs. Further, the MTO may not "disenroll" clients. MTO must serve all clients in its Managed Transportation Organization Regions.
438.228 - This section and Subpart F are not applicable to NEMT PAHPs. However, clients will have access to an internal MTO complaints process, HHSC complaint process, and a right to a fair hearing through HHSC.
438.236 - This provision does not apply to NEMT PAHPs.

☑ 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.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
   - **a.** ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

     Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **b.** ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
     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
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   - **A.** ☐ Initial credentialing
   - **B.** ☐ Performance measures, including those obtained through the following (check all that apply):
     - ☐ The utilization management system.
     - ☐ The complaint and appeals system.
     - ☐ Enrollee surveys.
     - ☐ Other.

       Please describe:
4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

   d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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:
   The procurement was conducted as a competitive negotiation in accordance with HHSC administrative rules, 1 Tex. Admin. Code Ch. 391. Texas Government Code § 2155.144 obligates HHSC to purchase goods and services on the basis of best value. HHSC rules define “best value” as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and that achieves health and human services procurement objectives (see 1 Tex. Admin. Code § 391.103(2). As stated in 1 Tex. Admin. Code § 391.103(2), HHSC may consider any of the following factors in determining best value:
   (1) purchase price;
   (2) meeting required specifications;
   (3) installation costs;
   (4) life cycle costs;
   (5) anticipated quality and reliability of the goods/services;
   (6) delivery terms;
   (7) respondent's performance under past contracts and ratings in the Comptroller's Vendor Performance Tracking System;
   (8) cost of any required training; and
   (9) other relevant factors for that specific contract.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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:

   MTO will have no incentive to market to "potential enrollees" because only one MTO will serve all clients in a Managed Transportation Organization Region.

☑ 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.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

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:

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:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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:

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.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

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

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

☐ The languages comprise all languages in the service area spoken by approximately [ ] percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
Section A: Part III: (1)(3)(a)(b)(1-15)(c)(1-7)(d)
Par IV: A: (2)(b)(1-3)

MTOs will have no incentive to market to "potential enrollees" because only one MTO will serve clients in the MTO Region.

HHSC allows the MTO to distribute NEMT approved materials. These include:
-Posters
-Brochures
-Outreach and informing on available NEMT services through mail-outs or flyers
-Desk reference

In addition to these materials, several other State programs provide information regarding NEMT:

-Other State program areas or vendors that work with the eligible population.
-2-1-1 Texas provides information on NEMT whether by phone or internet.
-Texas Department of State Health Services offers a link to the NEMT materials used by outreach staff.
-NEMT information is distributed to eligible clients with eligibility information.

The State translates all client materials to Spanish. HHSC and the MTO uses a language translation vendor for the translation services whenever necessary. The vendor offers translation services in 170 different languages. Additionally, HHSC and the

MTO allows the client's attendant to travel with them to offer translation services during their health care appointments when requested by the client.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

- [x] The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. [x] Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish

If the State does not translate or require the translation of marketing materials, please explain:

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

a. [ ] The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. [x] The languages spoken by approximately 36.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

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

HHSC uses a language translation vendor for the translation services whenever necessary. The vendor offers translation services in 170 different languages. Additionally, HHSC allows the clients attendant to travel with them to offer translation services during their healthcare appointments when requested by the client.

3. ☐ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State
☐ Contractor

Please specify:

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

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

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

☐ the State
☐ State contractor

Please specify:

☑ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
No additional information added.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

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:

42 C.F.R. 438.56 - The MTO must serve all eligible clients in its Managed Transportation Organization Region.

☑ 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.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

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:

Each MTO must develop outreach and informing marketing strategies and protocols to keep Medical Transportation Program (MTP) clients knowledgeable about program operation and proposed changes prior to implementation of changes. In addition, State staff conducts statewide stakeholder forums, posts notices on agency and claims administrator websites, and sends several mass mailings to MTP clients.

The State contracts with multiple vendors to conduct targeted outreach and informing to the clients through age 20. The outreach includes information regarding how to access NEMT services and assistance with contacting HHSC for arranging services to ensure access to necessary healthcare services. Materials can also be used for educating any client 21 and over regarding NEMT services. These include brochures, managed care handbook, Medicaid client handbook, information on the State website, and Medicaid toll-free line.

HHSC eligibility workers, Medical Transportation Program, and Department of State Health Services also conduct outreach and informing to clients through age 20 about NEMT services.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. **Details** (Continued)

b. Administration of Enrollment Process

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

  Broker name:

  Please list the functions that the contractor will perform:
  - ☐ choice counseling
  - ☐ enrollment
  - ☐ other

  Please describe:
- ☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. **Details** (Continued)

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

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

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

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

i.

☐ Potential enrollees will have ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

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

☐ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

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

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☐ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

- **i.** ☐ Enrollee submits request to State.
- **ii.** ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of [ ] months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

☐ The State does not have a **lock-in**, and enrollees in 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.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- **i.** ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

  Please describe the reasons for which enrollees can request reassignment

- **ii.** ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- **iii.** ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- **iv.** ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Part IV: (C)(2)(b) and (c) not applicable.
There are no potential enrollees and disenrollment is not allowed.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- ☐ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- ☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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:

  42 C.F.R.438.100, 42 C.F.R. 438.102, and 42 C.F.R. 438.104 - 1) MTO does not contract with healthcare professionals, just transportation providers.(2)MTO has no incentive to market to "potential enrollees" as only 1 MTO will serve all clients in a MTO Region.(3) MTO will not provide inpatient or outpatient services.42 C.F.R. 438.110 and 42 C.F.R. 438.114 do not apply to NEMT PAHPs.
- ☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- ☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- ☑ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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 section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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.

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.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

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

a. Direct Access to Fair Hearing

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

b. Timeframes

☐ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ____ days (between 20 and 90).
☐ The State's timeframe within which an enrollee must file a **grievance** is ____ days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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.

   ☑ 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 are operated by:
   - ☑ the State
   - ☐ the State's contractor.

     Please identify:
   - ☐ the PCCM
   - ☑ the PAHP

   ☑ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

   Please describe:

   The MTO must
   (1) develop a system for receiving, retaining, managing, resolving, and reporting client inquiries, complaints, grievances, and appeals to HHSC.

   See additional information

   ☑ 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:

   A client may request an Internal Review; a Medical Transportation Administrative Review; and a Fair Hearing. A client may also voice his or her complaints to the HHSC Office of the Ombudsman.

   See additional information

   ☑ Specifies a time frame from the date of action for the enrollee to file a request for review.

   Please specify the time frame for each type of request for review:

   The client has the right to appeal within 90 days from, the date on the notice of agency action, or the effective date of the agency action, whichever is later.

   ☑ Has time frames for resolving requests for review.

   Specify the time period set for each type of request for review:

   The MTO must respond to client service delivery complaints within 5 days, Ombudsman complaints within 3 days, and Legislator's office complaints within 24 hours.

   ☐ Establishes and maintains an expedited review process.

   Please explain the reasons for the process and 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:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
Continued from Section A: Part IV: E Grievance System 4.

*Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

(2) ensure that the inquiries, complaints, grievances, and appeals data contains details regarding the nature of the issue, the process to resolve the issue, and final determination. This information should be made available to HHSC upon request.
(3) ensure that inquiries, complaints, grievances, and appeals inquiries are responded to within a predetermined timeframe.

*Has a committee or staff who review and resolve requests for review.

An Internal Review is conducted by the MTO in an attempt to explain or resolve a complaint from a client relating to the denial, reduction, or delay of a transportation service for which that client is, or believes to be, eligible.

A Medical Transportation Administrative Review is conducted by MTP in an attempt to explain or resolve a complaint from a client relating to an MTO's denial, reduction or delay of providing transportation service for a client.

A Fair Hearing is heard by an impartial HHSC Hearings Officer where the MTO must represent the case for HHSC.

In addition, State staff monitor and approve the grievance system of the MTO. Through its monitoring activities, the State will determine an MTO's compliance with state-approved grievance, complaint, and appeal processes; Texas administrative code rules specific to fair hearings and the Medical Transportation Program; implementation of final fair hearing decisions; and MTO internal system processes documented in the call center operations manual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. **Assurances**

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

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

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

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

a. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

b. 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;

c. Employs or contracts directly or indirectly with an individual or entity that is

i. Precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

ii. Could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
No additional information added.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section 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 column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section 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 column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section 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 column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO	☐ MCO	☐ MCO

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
MTO NEMT	PAHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: MTO Nonemergency Medical Transportation

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:

- 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)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

c. ☑ **Consumer Self-Report data**

Activity Details:
The MTOs are required to contract with an independent research organization to conduct client and medical service provider satisfaction surveys. The survey should include a statistically significant number of clients, Performing Providers, type of service and medical providers, including a statistically significant subset of clients with Limited English Proficiency (LEP). The research organization client sample must include services from 25% of the Performing Providers each quarter to ensure 100% of all Performing Providers are surveyed annually. The MTO must maintain a 95% client satisfaction survey result as determined by the survey conducted by the independent research organization. The survey results and analysis of those responses must be submitted directly to the State by the independent research organization no later than 60 days after the completion of the surveys.

The frequency of use is quarterly.

Results provide information on client satisfaction with access, quality of service, continuity and coordination of services, quality of the management of delivery of NEMT services, as well as satisfaction among Performing Providers and medical providers.

For clarification, it is the responsibility of the Managed Transportation Organizations (MTOs) to conduct satisfaction surveys. The State did not conduct satisfaction surveys.

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:
The MTO must provide complete Encounter Data for all transportation services including meals, lodging, and advanced funds.

The MTO must develop a system for receiving, retaining, managing, resolving, and reporting client inquiries, complaints, grievances, and appeals to HHSC.

Personnel responsible: Managed Transportation Organizations

Detailed description of activity: The Managed Transportation Organizations (MTO) use their Encounter Data system continuously in order to stay compliant with the Encounter Data submission requirements. The MTOs are required to submit complete and accurate Encounter Data at least once a month and not later than the 30th calendar day after the last day of the month in which the claim was adjudicated. In addition, the Encounter Data must follow the format and data elements described in the HIPAA-compliant 837P Companion Guides and TMHP's Encounter Submission Guidelines and Companion Guide.

Frequency of use: At a minimum monthly

How it yields information about the area(s) being monitored: There are two layers of validation performed on Encounter Data transactions. First, HIPAA validation is performed to ensure compliance with the ASC X12 HIPAA format. The transactions which do not pass this layer of validation will be rejected. Second, the Encounter Data transactions will be checked against the established HHSC Business Edits. Some of the edits will cause an

encounter to be rejected while others edits will allow the encounter to be accepted. After each Encounter Data file submission, a series of response files are generated to the MTO with acknowledgement and the acceptance status. The MTOs use these files to identify and resubmit the encounters that were rejected or accepted with errors. Furthermore, HHSC and its third party vendor continue to hold monthly meetings with each of the MTOs to discuss encounter data submission and any anomalies that may arise.

Grievances and Appeals: Anytime an MTO denies a client's claim for NEMT services the client may request a review or appeal by the MTO, HHSC, or an administrative law judge. If an administrative review is requested by HHSC, HHSC works with the MTO to resolve the issue. It is the responsibility of the MTO to send a letter to the client notifying them of the outcome. The client still can request a review by an administrative law judge. Grievances other than those related to claims are handled through the complaint process.

- [ ] **Denials of referral requests**
- [ ] **Disenrollment requests by enrollee**
  - [ ] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [ ] **Other**

Please describe:

e. [ ] **Enrollee Hotlines**

Activity Details:

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)

Activity Details:

g. [ ] **Geographic mapping**

Activity Details:

h. [x] **Independent Assessment** (Required for first two waiver periods)

Activity Details:

Personnel responsible: State staff

Detailed description of activity: Pursuant to Section 2111(B) of the State Medicaid Manual, the State must arrange for an independent evaluation or assessment of the NEMT waiver program and submit findings when renewing the waiver program. The independent assessment evaluates beneficiary access to services under the waiver, quality of waiver services, and cost effectiveness of the waiver. The State procures and enters in a contract with an independent assessment entity that does not have any direct or indirect relationship with any program managed care entities. The independent assessment entity must have certain qualifications (e.g., education, knowledge of study methodology, financial management experience, etc.) required to perform the assessment.

Frequency of use: As required.

How it yields information about the area(s) being monitored: The results of the evaluation are reviewed by State staff. The recommendations made by the independent consultant are evaluated for feasibility and appropriateness based on business needs, cost-effectiveness, and impact to the State's Medicaid program and service delivery. System changes are discussed with the MTOs through roundtable discussions and annual summits to solicit their feedback and initiate changes, if warranted. State staff reviews the feedback and determines if the recommendations can be implemented immediately, through a phased in approach, or require further analysis.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☑ **Ombudsman**

Activity Details:

Clients may submit complaints to the HHSC Office of the Ombudsman. The MTO must respond to Ombudsman complaints within 3 days.

When clients file Ombudsman complaints the information gathered enables MTP to identify the nature of issue and investigate further into operational processes of the MTO's and FRB's in an effort to improve services.

The information received through Ombudsmen complaints identifies the nature(s) of the issue contained in the complaint. HHSC uses this information to gauge issues with the delivery of NEMT services, client satisfaction and areas where additional monitoring or guidance may be required. HHSC also tracks the nature of issues from month to month to determine if the provider is improving and/or if the guidance provided is improving service delivery outcomes. If improvement is not seen corrective action may be taken in the form of liquidated damages and/or issuance of a corrective action plan.

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

☐ **Clinical**

☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

☐ **Process**

☐ **Health status/ outcomes**

☐ **Access/ availability of care**

- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☑ **Provider Self-Report Data**

Activity Details:
The MTO will submit timely and complete Performing Provider monitoring reports to HHSC. This information is located within the Independent Assessment document.

- ☐ **Survey of providers**
- ☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☑ **Other**

Activity Details:
The MTO must obtain approval from HHSC for all written materials developed by the MTO prior to dissemination. The MTO must submit to HHSC all policies and procedures, client notices, client letter templates, client education materials, and Performing Provider notifications within 30 days of contract award.

Monitoring activities are guided by a risk-based monitoring plan that is developed using key requirements of the contract, agency rules, and state and federal laws. Each element is weighted based on the level of risk posed that may impact effective program operations, agency business needs, and cost containment strategies.
Organizationally, the Contract Management Operations Unit serves as the hub for four other functional areas in the MTP. The unit is led by a contract administrator and varied levels of contract staff that are responsible for ensuring transportation providers adhere to the terms and condition of their contract. Monitoring activities are guided by the level of risk. Examples of strategies used are noted below:
• Validation of transportation services will be conducted through quarterly matching of transportation claims against a Medicaid covered healthcare event. MTP staff worked collaboratively with the Claims Administrator to establish a matching logic.
• Driver standards are monitored through the validation of driver's license, training, driver records, drug and substance abuse checks, and criminal history checks.
• Vehicles are checked for updated annual inspections and vehicle registrations.
• Call center metrics are reviewed monthly to ensure compliance with Frew measures.
• Financial reviews will be conducted using contractually required submission of

deliverables (i.e., financial statements, annual financial audits, and Financial Statistical Report conducted by an independent financial consultant).
• The level of transportation capacity was initially reviewed during the review of responses to the Request for Proposal. In most of the responses, the transportation providers conducted a vehicle demand analysis using projected client population data provided by the State. Monitoring will occur principally through client satisfaction surveys and complaints. The MTO contract contains provision for assessment of liquidated damages for failure to comply with the terms and conditions of the contract. The State works with the MTOs and offers an opportunity for corrective action.

Section C: Monitoring Results

Renewal Waiver Request

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 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** The State provides below the results of the monitoring activities conducted during the previous waiver period.

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.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Satisfaction Surveys

Contracted providers submit client and provider customer satisfaction surveys on a quarterly and annual basis. Since the providers each contract with a different independent research organization to conduct the surveys there was some variance in the questions asked. To streamline the surveys so that a better cross comparison can be done HHSC conducted a roundtable discussion with all of the MTOs to discuss satisfaction surveys, provide guidance with respect to the population that should be surveyed, review the questions being asked and the manner in which the surveys were being conducted. Desk reviews of the customer satisfaction surveys and results are conducted and feedback is given to the providers with respect to the

outcomes. Providers are meeting this requirement and HHSC continues to work with each of the MTOs to further streamline and strengthen the data derived from the satisfaction surveys.

Encounter Data

All of the contracted providers successfully submit encounter data. HHSC and its third party vendor continue to hold weekly and monthly meetings with each of the MTOs to discuss encounter data submission and any anomalies that may arise. In addition, HHSC conducts desk reviews with respect to the encounter data submitted by each of the MTOs and the percentage of those that match a covered health care service. The average match rate for the MTOs is 93%. For unmatched encounters each of the MTOs are provided a random sample and are required to submit a verification from the healthcare provider that the client attended a covered health care service. This is an ongoing process as the managed care plans have up to 24 months to submit the corresponding health care encounter.

Ombudsman

Each of the MTOs are required to respond to complaints filed with the Office of the Ombudsman within three (3) days. If an MTO does not respond within the required timeframe they are sent two reminder notices. Any subsequent failure to respond is addressed my management. Compliance with this requirement is high. If a provider fails to respond within the required timeframe and does not implement action to correct the issue they may be assessed liquidated damages and/or placed on a corrective action plan.

Complaints

The contracted providers are required to provide an answer to general complaints within five (5) days, Ombudsman complaints within three (3) days, and legislative complaints within 24 hours. In addition to providing an answer to the complaint the provider must also identify actions that will be taken to ensure the issue is addressed to minimize or eliminate reoccurrence. Score cards are compiled and provided to each of the MTOs on a monthly basis regarding complaints which outlines the number of complaints the MTO received in a month versus statewide complaints, the top five (5) nature of issues, and the subcontractors complaints were filed against. In addition complaints are reviewed to ascertain trends in complaints against particular drivers. All complaint information is shared with the MTOs for immediate action. If complaint issues are not addressed, the MTO may be addressed liquidated damages and/or placed on a corrective action plan. Compliance with this requirement is good. All of the MTOs continue to work with HHSC to ensure safe, efficient and cost effective transportation services are provided to all clients eligible and receiving services under this waiver.

Performing Providers

HHSC monitors the contracted providers, its subcontractors and their drivers to ensure compliance with all of the provisions of the contract. Extensive desk reviews are done in which subcontractor and driver compliance are monitored to include ensuring drivers meet all requirements such as drug testing, sex offender registry check, criminal background check and moving violations. MTOs are notified of any areas of noncompliance identified via the desk reviews and actions are taken to ensure noncompliant drivers are prohibited from providing services to clients receiving services under this waiver. Additionally, desk reviews are conducted to ensure the MTOs are making timely payments to their subcontractors and to ensure the subcontractors meet contract terms, including being properly registered to conduct business in the state, obtaining and carrying adequate insurance, and that they not excluded from providing Medicaid services. If issues are identified and not corrected in a timely manner, the MTO may be addressed liquidated damages and/or placed on a corrective action plan. Compliance with this requirement is high.

Satisfaction surveys were completed by independent research organizations hired by the MTO in SFY 2015 and 2016. Overall, the level of satisfaction with services delivered through the MTOs conforms with contract requirements. Clients' level of satisfaction rates is consistently at or above the 95% threshold.

Identify Problems: Issues identified in the previous surveys include:

•Performing Providers request for uniform delivery of information;
•Performing Providers and medical provider requests for timely responses from call center agents;
•Performing Providers request training and support from the MTO;
•Performing Providers request the MTO increase the percentage of completed calls to remind clients that they have an appointment scheduled the following day; and
•Clients and/or medical providers request outreach and informing efforts about NEMT services.

The MTOs are responsible for identifying deficiencies and developing strategies that are included in their performance improvement plan for each Performing Provider, if needed. Areas identified in plan are monitored by the HHSC and the MTOs to ensure compliance and/or to ensure necessary changes or identified areas requiring improvement are fully implemented. The State conducts monitoring and necessary training and provides guidance or direction, as needed.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
NEMT-All Services	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2014	09/30/2015	10/01/2015	06/30/2016
Enrollment Projections for the Time Period*	04/01/2017	03/31/2018	04/01/2018	03/31/2019
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
MTO Nonemergency Medicial Transportation	☑	☐	☐	

Section D: Cost-Effectiveness

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.

Signature: Kathi Montalbano

State Medicaid Director or Designee

Submission Date: Sep 29, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Greta Rymal

c. Telephone Number:

(512) 424-6919

d. E-mail:

greta.rymal@hhsc.state.tx.us

e. The State is choosing to report waiver expenditures based on

- ◉ **date of payment.**
- ○ **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. 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.*

- **b.** ☐ The State provides additional services under 1915(b)(3) authority.
- **c.** ☐ The State makes enhanced payments to contractors or providers.
- **d.** ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.
- **e.** ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *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***
- 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.

Section D: Cost-Effectiveness

Part I: State Completion Section

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.** ☐ **PCCM**
- **e.** ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. ☐ **Year 1: $** _____ **per member per month fee.**
2. ☐ **Year 2: $** _____ **per member per month fee.**
3. ☐ **Year 3: $** _____ **per member per month fee.**
4. ☐ **Year 4: $** _____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

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

d. ☐ **Other reimbursement method/amount.**

$ _____

Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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:

Member month projections were provided by HHSC's System Forecasting division which is responsible for all of the state's Medicaid enrollment forecasts. The forecasted increase in membership from the base period to the projection periods is based on System Forecasting's analysis of state population growth, Medicaid eligibility growth and the impact of the Affordable Care Act.

d. ☑ [Required] Explain any other variance in eligible member months from BY/R1 to P2:
No other variance is included in the enrollee month projections

e. ☑ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
R1 is FFY2015. R2 is the partial year 10/1/2015 through 6/30/2016.

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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.

Only NEMT services are included in this waiver. These services are not included in the State's other approved 1915(b) waivers. Therefore, there will not be overlapped or duplicated expenditures reported in the CMS-64 Summary.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
MTO Nonemergency Medicial Transportation	☐	☐	☐	☐	☐	☑	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

c. ☑ **Other**
Please explain:

The State allocates the administrative costs to the Medical Transportation Program based upon the proportion of program cost and unduplicated medical transportation recipients to total Medicaid costs and caseload. Cost and caseload reflect only those service areas included in this waiver. The counties included are listed in Section D. Geographic Areas Served by the Waiver. The expenses shown in Appendix D2.A are based on actual NEMT administrative expenses during the R2 period. These R2 NEMT administrative expenses were adjusted to reflect the limited service area included in the waiver. A 3 percent annual inflation adjustment was applied to the actual base year administrative expenses to project P1 through P5 administrative expenses. The P1 adjustment factor shown in cell Y13 of Appendix D5 is 4.8 percent because the length of time between the mid-point of R2 and the mid-point of P1 is 19.5 months.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

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

c. ☑ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require 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**
   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

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

   Document
   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)

Document:

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.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

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: 5.00

      Please document how that trend was calculated:

      The assumed trend rate was determined based on an analysis of historical NEMT cost experience and the actuary's professional judgment regarding future cost increases. This trend adjustment is independent of any programmatic/policy/pricing changes. In analyzing historical experience, adjustments were made to recognize programmatic changes regarding the management of transportation services and eligibility for Advance Funds services.

The inflation adjustment factor for P1 (cell J13 of Appendix D5) is 8.0%. This is greater than 5.0% because the length of time between the mid-point of R2 and the mid-point of P1 is 19.5 months.

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.

   The trend assumption is based on program experience during the periods SFY2014, SFY 2015 and partial SFY2016. For the projection of waiver costs, we utilized a linear regression model to analyze monthly NEMT claims experience for the applicable service areas for the incurred period September 1, 2013 through March 31, 2016. In analyzing historical trends, adjustments were made to recognize programmatic changes regarding the management of transportation services and eligibility for Advance Funds services. In addition, our evaluation included the actuary's judgment regarding future cost changes. The state's trend adjustment assumption includes the combined impact of changes in utilization and inflation.

   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.**

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. 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
- 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. 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.
Please list the changes.
1) The service area regions included in the waiver have changed since the beginning of the retrospective period. Effective June 1, 2015, Region 8 was moved from this waiver to the State Plan. Effective August 1, 2016, Region 4 was moved from this waiver to its own 1915 (b)(4) waiver. Effective September 1, 2017, Regions 1 and 10 will move from this waiver to the State Plan... –see 2.i.E. Other-

For the list of changes above, 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
58.00

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☑ Other:
Please describe
.. As a result of these changes, the average cost of services will differ between the retrospective periods and the projection periods. These changes have been considered in deriving the Program Adjustment factor.
2) It is our understanding that the Member Months and State Plan Service Costs for R1 and R2 shown on Appendix D1 and Appendix D3.. –see 2.v. Other-

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 list the changes.

For the list of changes above, 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 list the changes.

For the list of changes above, please report the following:

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

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☐ Other
Please describe

v. ☑ Other
Please describe:
..should be equal to the amounts reported on the CMS 64 report and we have done so. The CMS 64 for the NEMT waiver contains incorrect reporting of State Plan Service Costs. The report includes service costs for all MTO regions, rather than only those regions included in the waiver. As a result, we have included in the Program Adjustment factor. –see 2.v.D.
Other-

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

..continued from 2.v.Other... an adjustment to recognize the overstatement of average service cost per member month reflected in the CMS 64 report and on Appendix D3. This Program Adjustment factor is independent of any trend assumption or other programmatic/policy/pricing changes.

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

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 fee-for-service program then the State needs to estimate the impact of that adjustment.

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

2. ☑ An administrative adjustment was made.

i. ☐ 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 PMPM

size of adjustment

Please describe:

D. ☑ Other

Please describe:

This adjustment projects the Retrospective Period (R2) to P1 through P5. The P1 adjustment factor shown in cell Y13 of Appendix D5 is 4.9 percent (equals 1.03^ (19.5/12)-1) because the length of time between the mid-point of R2 and the mid-point of P1 is 19.5 months. The P2 factor shown in cell Y30 of Appendix D5 is the 3.0 percent annual inflation assumption from P1 to P2.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1]
The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i.

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

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

2. Please provide documentation.

B. State Plan Service trend

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

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

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

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

3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- 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. This adjustment must be mathematically accounted for in Appendix D5.

Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

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

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

   Member month projections were provided by HHSC's System Forecasting division which is responsible for all of the state's Medicaid enrollment forecasts. The forecasted change in membership from R2 to P1 is based on (i) changes in the service regions included in the waiver (described above in Section A.1.) and (ii) System Forecasting's analysis of state population growth, Medicaid eligibility growth and the impact of the Affordable Care Act.
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:

   As noted above in Sections D.1.I. and D.1.J., unit cost adjustments were made to recognize the following: (i) service area changes, (ii) incorrect reporting on the CMS 64 report and (iii) trend.

   The service area regions included in the waiver have changed since the beginning of the retrospective period. Effective June 1, 2015, Region 8 was moved from this waiver to the State Plan. Effective August 1, 2016, Region 4 was moved from this waiver to its own 1915(b)(4) waiver. Effective September 1, 2017, Regions 1 and 10 will move from this waiver to the State Plan. As a result of these changes, the average cost of services will differ between the retrospective periods and the projection periods. These changes have been considered in deriving the Program Adjustment factor.

It is our understanding that the Member Months and State Plan Service Costs for R1 and R2 shown on Appendix D1 and Appendix D3 should be equal to the amounts reported on the CMS 64 report and we have done so. The CMS 64 for the NEMT waiver contains incorrect reporting of State Plan Service Costs. The report includes service costs for all MTO regions, rather than only those regions included in the waiver. As a result, we have included in the Program Adjustment factor an adjustment to recognize the overstatement of average service cost per member month reflected in the CMS 64 report and on Appendix D3.

We have assumed a 5.0 percent annual trend in the cost of waiver services. The trend assumption is based on program experience during the periods SFY2014, SFY 2015 and partial SFY2016. For the projection of waiver costs, we utilized a linear regression model to analyze monthly NEMT claims experience for the applicable service areas for the incurred period September 1, 2013 through March 31, 2016. In analyzing historical trends, adjustments were made to recognize programmatic changes regarding the management of transportation services and eligibility for Advance Funds services. In addition, our evaluation included the actuary's judgment regarding future cost changes. The state's trend adjustment assumption includes the combined impact of changes in utilization and inflation and is independent of any other unit cost adjustment.

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

The state's trend adjustment assumption includes the combined impact of changes in utilization and unit cost.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary