Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Virginia** 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
CCC+	Commonwealth Coordinated Care Plus	MCO;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Commonwealth Coordinated Care Plus Waiver - Expansion Amendment

C. Type of Request. This is an:

☑ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):
This amendment modifies the current CCC Plus Waiver to cover a portion of Virginia's Medicaid Expansion Population by enacting additions to the following sections of the waiver as described below:

1. Main Facesheet, 1 (part 1 of 2),D: The proposed effective date of this waiver is 01/01/19.

2. Section A, Part I Program Overview: Tribal Notification section was updated to reflect date of notification.

3. Section A, Part I Program Overview, A. Statutory Authority (3 of 3): The "additional information" section was updated to reflect the description of expansion enrollment and estimated number of enrollees.

4. Section A, Part I Program Overview, D. Geographic Areas Served by the Waiver (1 of 2), 2. Details: The "Details" Section was updated to remove Humana.

5. Section A, Part I Program Overview, E. Populations Included in Wavier (part 1 of 3), "Other": The "other" section of the "included populations" field was updated to include a description of the CCC Plus expansion population.

6. Section A, Part I Program Overview, E. Populations Included in Waiver (part 2 of 3), 2. Excluded Populations, "Other": The "other" section of the "excluded populations" field was updated to indicate populations excluded from this waiver also include individuals enrolled in the new Medallion 4.0 program.

7. Section A, Part I Program Overview, F. Services (5 of 5), The "additional information" section was updated to include the benefits and service coverage for those in the Medicaid Expansion population.

8. Section A, Part II Access, C. Coordination and Continuity of Care Standards (2 of 5), 2, b & c was updated to include a description of the identification and assessment of the Medicaid Expansion population.

9. Section A, Part II Access, C Coordination and Continuity of Care Standards (5 of 5), "Additional Information" was updated to describe additional continuity of care standards for the Medicaid Population.

10. Section A, Part IV Program Operations, B. Information to Potential Enrollees and Enrollees (5 of 5), The "Additional Information" section was updated to include notification information for the Expansion Population

11. Section A, Part IV Program Operations, C. Enrollment and Disenrollment (2 of 6), 2(a) Details. This section was updated to include the Outreach for the Medicaid expansion population.

11. Section A, Part IV Program Operations, C. Enrollment and Disenrollment (4 of 6), 2(c) Details. This section was updated to include the implementation schedule for the Medicaid expansion population.

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:VA.026.00.11

Waiver Number:VA.0877.R00.02

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: 07/01/17
Proposed Effective Date: *(mm/dd/yy)*
01/01/19

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

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

Name:	Matthew Behrens
Phone:	(804) 625-3673 **Ext:** **TTY**
Fax:	
E-mail:	matthew.behrens@dmas.virginia.gov

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:

☐ **Commonwealth Coordinated Care Plus**

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.
Tribal representatives were notified by DMAS on June 7, 2018 and made aware of the Department's intention to submit proposed waiver changes associated with Medicaid Expansion and the tribal comment period for the proposed waiver changes.

Tribal representatives were notified by DMAS on June 7, 2018 and made aware of the Department's intention to submit proposed waiver changes associated with Medicaid Expansion and the tribal comment period for the proposed waiver changes.

Additionally, DMAS staff will visit all six (6) tribes prior to the implementation of this expansion amendment to provide training and consultation.

Robert Gray, Chief
Pamunkey Indian Tribe
Pamunkey Indian Tribal Office
1054 Pocahontas Trail
King William, VA 23086

Stephen Adkins, Chief
Chickahominy Indian Tribe
8200 Lott Cary Road
Providence Forge, VA 23140

Chickahominy Indian Tribe, Eastern Division

2895 Mt. Pleasant Road
Providence Forge, VA 23140

Dean Branham, Tribal Chief
Monacan Indian Nation Inc.
P.O. Box 1136
Madison Heights, VA 24572

Barry Bass, Chief
Nansemond Indian Tribe
1001 Pembroke Lane
Suffolk, Virginia 23434

G. Anne Richardson, Chief
Rappahannock Tribe
5036 Indian Neck Road
Indian Neck, VA 23148

Upper Mattaponi Tribe
P.O. Box 184
King William, VA 23086

Program History required for renewal waivers only.

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*
☐ **CCC+**

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*
☐ **CCC+**

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*
☐ **CCC+**

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*
☐ **CCC+**

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*
☐ **CCC+**

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*
☐ **CCC+**

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*
☐ **CCC+**

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).

-- *Specify Program Instance(s) applicable to this statute*
☐ **CCC+**

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*
☐ **CCC+**

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:
The Medicaid Expansion population will be enrolled into one of two Managed Care Programs depending on whether they classify as medically complex or non-medically complex. Individuals classified as medically complex will be enrolled into the CCC Plus program. Individuals classified as non-medically complex will be covered under the Medallion 4.0 program.

On and before January 1, 2019, individuals included in the Medicaid Expansion population who are already enrolled in a limited benefit program or who are members of certain selected populations will be classified as either "medically complex" or "non-medically complex." Members of other selected populations are deemed to be medically complex without having to self-identify. Thereafter, all Medicaid applicants will attest to being either "medically complex" or "non-medically complex" on their Medicaid applications.

A member who attests to being medically complex is presumed to be medically complex, and likewise, a member who attests to being non-medically complex is presumed to not be medically complex. These presumptions can be rebutted by the results of part 1 of a MCO Member Health Screening (MMHS) administered to the member. If the MCO is unable to contact a Member to administer the MMHS or if the Member refuses to participate in the MMHS in its entirety, the Contractor shall notate this on the MMHS and the Member will be covered under the Medallion 4.0 program.

Individuals who are deemed by the Department to be medically complex or who self-identify as medically complex and whose MMHS indicates that they are medically complex will be enrolled in CCC Plus. If the MMHS results show that the member is not medically complex, the member will be transferred from CCC Plus to Medallion 4.0. Members will remain in the same health plan in Medallion 4.0 that they had for CCC Plus.

A member who attests to not being medically complex will initially be enrolled in the Medallion 4.0 program and will be assigned an MCO. If the MMHS results show that the member is medically complex, the member will be transferred from Medallion 4.0 to CCC Plus. Members will remain in the same health plan in CCC Plus that they had for Medallion 4.0.

DMAS will use the following managed care health plan assignment process for the Medicaid expansion population.

Populations enrolled for a January 1, 2019 effective date:
Managed Care eligible populations enrolled prior to December 18, 2018 will not have an initial fee-for-service enrollment period. These populations will be auto-assigned a health plan as follows:

1) For Members with a Managed Care case history, such as parents of children already enrolled in Medicaid, the Department shall assign the parent to the same MCO with whom their dependent is enrolled.

2) For other individuals the Department shall randomly assign each Member to a MCO in the individual's locality.

3) Members will have ninety (90) days to from their initial MCO effective date to change their plan for any reason until the next expansion open enrollment period. A member can change their plan at any time with cause.

Initial Managed Care Assignments on and after December 19, 2018:
Following the initial managed care assignment on December 18, 2018, members will be enrolled in fee-for-service briefly until they are managed care enrolled. During this timeframe, an individual may preselect their MCO. Individuals who do not preselect a plan will be auto-assigned to an MCO as described above.

Open Enrollment:
Individuals eligible through Medicaid expansion will have an open enrollment period from November 1 – December 31. Selections made on or before the December managed care assignment date (December 18th) will be effective January 1; selections between December 19 and December 31 will be effective February 1st. Within sixty (60) calendar days prior to the open enrollment begin date, the Department will inform Members of the opportunity to remain with the current plan or change to another plan without cause. Those Members who do not choose a new health plan during the open enrollment period shall remain in their current health plan until their next open enrollment period.

DMAS estimates that approximately 15,000 GAP members, 105,000 Plan First members, and 85,000 SNAP members will be eligible for Medicaid Expansion.

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.)

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:

Section A: Program Description

Part I: Program Overview

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

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

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

Program: " **Commonwealth Coordinated Care Plus.** *"*

- [x] **Two or more MCOs**
- [ ] **Two or more primary care providers within one PCCM system.**
- [ ] **A PCCM or one or more MCOs**
- [ ] **Two or more PIHPs.**
- [ ] **Two or more PAHPs.**
- [ ] **Other:**

please describe

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.
   - (•) **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*
     - [x] **CCC+**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     - [ ] **CCC+**
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)
ALL LOCALITIES	MCO	Aetna Better Health of Virginia
ALL LOCALITIES	MCO	Anthem HealthKeepers Plus
ALL LOCALITIES	MCO	Magellan Complete Care of Virginia
ALL LOCALITIES	MCO	Optima Health
ALL LOCALITIES	MCO	United Healthcare
ALL LOCALITIES	MCO	Virginia Premier Health Plan

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:

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**

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

- (●) **Mandatory enrollment**
- ( ) **Voluntary enrollment**

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

- (●) **Mandatory enrollment**
- ( ) **Voluntary enrollment**

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

- (●) **Mandatory enrollment**
- ( ) **Voluntary enrollment**

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

- (●) **Mandatory enrollment**
- ( ) **Voluntary enrollment**

☐ **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):

CCC+ Expansion - Included Populations:
The Medicaid Expansion Population is defined as Adults ages nineteen (19) through sixty-four (64) who are not eligible for Medicare coverage or for a mandatory coverage group, and whose income does not exceed 138% of the Federal Poverty Level.

The Medicaid Expansion population will be enrolled into one of two Managed Care Programs depending on whether they classify as medically complex or non-medically complex. Individuals classified as medically complex will be enrolled into the CCC Plus program. Individuals classified as non-medically complex will be covered under the Medallion 4.0 program.

Individuals who are receiving limited benefits through Medicaid (such as GAP or Plan First) with income at or below 138% of the Federal poverty level will be enrolled in full benefit Medicaid effective date of January 1, 2019.

Individuals eligible for Medicaid Expansion who are in the Supplemental Nutrition Assistance Program (SNAP) or who are a parent of a current Medicaid enrollee will be enrolled with a Contractor with an effective date as soon as January 1, 2019.

Individuals eligible through Medicaid expansion who are not known to the Department will be enrolled through the standard application process with a CCC Plus effective date as soon as January 1, 2019 and no later than 60 days of approval of the application.

Individuals may apply for coverage through Cover Virginia at http://www.coverva.org, as well as through local Departments of Social 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):
  CCC+ Expansion - Excluded Populations:

  1)Individuals with temporary coverage or who are in limited coverage groups, including:
  a. Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention) who are not included in the Medicaid expansion population.

  2) Individuals who are included in the Medicaid expansion populations who are not identified as "medically complex." These individuals are covered through the Medallion 4.0 program.

  All other Excluded Populations:
  All excluded populations are those enrolled in:
  •Limited Coverage Groups (Health Insurance Premium Programs, Family Planning, Governor's Access Plan,

Qualified Medicare Beneficiary only.)
•Residents of Intermediate Care Facility-Intellectual Disability Facilities (Only those who reside in an ICF/MR are excluded. NF residents are included.)
•Residents of Veterans Nursing Facilities
•Residents of Psychiatric Residential Treatment Level C
•Money Follows the Person members
•Individuals enrolled in a Medicaid-approved hospice program will not be auto-enrolled. However, if an individual enters a hospice program while enrolled in the CCC Plus program, the member will remain enrolled in CCC Plus for those services.
- Individuals with end stage renal disease (ESRD) and in fee-for-service at the time of enrollment will be auto-enrolled into the CCC Plus program but may request to be disenrolled and remain in fee-for-service. DMAS will manually exclude these individuals if requested by Member within the first ninety (90) days of CCC Plus enrollment. However, an individual who does not request exclusion within the first ninety (90) days of CCC Plus enrollment or who develops ESRD while enrolled in the CCC Plus program will remain in CCC Plus.
•Medallion 3.0 and FAMIS MCO members (Except the Aged, Blind and Disabled individuals that will transfer on January 1, 2018. Additionally, DMAS will amend the Medallion 3.0 waiver to exclude the populations that will be included under this waiver.)
•PACE members

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:

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):

The Contractor is responsible for all EPSDT services for their Members under age twenty-one (21). EPSDT services for Members under age twenty-one (21) also apply to the Medicaid Expansion population. Federal EPSDT regulations provide that all eligible Medicaid recipients under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation. Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCO's, primary care physicians (PCPs) and EPSDT screening providers.

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)

Individuals in the Medicaid Expansion population, shall receive the same amount, duration and scope of services as other Medicaid Members, with the following four (4) additional federally-required essential health benefits, according to the United States Preventive Services Task Force (USPSTF).
1) Annual adult wellness exams;
2) Individual and group smoking cessation counseling;
3) Nutritional counseling for individuals with obesity or chronic medical diseases;
4) Recommended adult vaccines or immunizations.

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:
All newly enrolled CCC Plus Members beginning January 1, 2019 will be screened using the MMHS which determine if a Health Risk Assessment (HRA) is needed and to triage HRA completion timeframes. The MMHS will not replace the current HRA.

A face to face HRA is required to be performed by the MCO when the MMHS identifies a high risk Member, a Member in the CCC Plus Waiver, a Member residing in a nursing facility, or a Member with a serious mental illness. HRAs will be conducted on our emerging high risk Members but are not required to be conducted face to face, except as requested or as needed. Members for whom an HRA is not completed, the development of an individualized care plan (ICP) or the arrangement of an Interdisciplinary Care Team (ICT) will not be required.

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.

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:

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:

☑ 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.

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:

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**

- [x] The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- [ ] The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

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

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

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:

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:

The CCC Plus program covers individuals in the Medicaid expansion population who have medically complex conditions. The Medallion 4.0 program covers individuals in the Medicaid expansion population without medically complex conditions.

As defined by the State of Virginia, "medically complex" individuals are those who have a complex medical or behavioral health condition and a functional impairment based on the MMHS.

An individual who attests to being medically complex is presumed to be medically complex, and likewise, a member who attests to being non-medically complex is presumed to not be medically complex. These presumptions can be rebutted by the results of Part 1 of a MMHS administered to the member. Those whose attestations have been confirmed through the MMHS will be enrolled in CCC Plus.

"Attestation" means the applicant responds to two questions on his/her Medicaid application with either a yes or no answer: 1) Do you need help with everyday things like bathing, dressing, walking, or using the bathroom to live safely in your home? 2) Has a doctor or nurse told you that you have a physical disability or long term disease, mental illness or addiction problem?

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:

The MMHS administered consists of questions that provide insight on the population, identify opportunities for supports, and support clinical pathways to improved outcomes. The MMHS will be used to determine if a Health Risk Assessment (HRA) is needed for the expansion population and to triage the completion timeframes. The MMHS will not replace the current HRA.

Part 1 of the MMHS contains questions that will be used to determine if a member is medically complex, as well as an answer key that includes instructions on how to determine if a member is medically complex based on the member's answers to the questions in Part 1. Part 2 of the MMHS contains questions regarding social determinants of health, and those responses are used in the medical complexity determination.

Part 1 and Part 2 of the MMHS is administered to all newly enrolled individuals in the CCC Plus Program.

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:

CCC Plus Members for whom an HRA is not completed, the development of an individualized care plan (ICP) or the arrangement of an Interdisciplinary Care Team (ICT) will not be required.

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.
Expansion members will be assigned an MCO based on member choice, family members who are already enrolled in an MCO, or random assignment. The member will be notified in writing that he can choose a different MCO for any reason without cause during the first 90 days of initial eligibility by calling the DMAS enrollment broker, Maximus, or by utilizing their web site or new smart phone mobile application to make an informed MCO choice. The member may change their MCO at any time for cause. Each MCO provides its network provider data to Maximus by provider type to allow members to choose an MCO that their doctor is enrolled with. Additionally, DMAS will be carrying out an extensive training effort for members and providers in each region of the state both in-person and using webinars. All MCOs will be required to attend these sessions, give a brief overview of their operations, and answer questions. The open enrollment period for expansion members will follow the ACA health insurance exchange open enrollment time period of November and December for a January 1st effective date.

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:
For new populations such as the Medicaid Expansion population, including those with out of network providers, the continuity of care period is 30 days.

The Medicaid Expansion population shall maintain their MCO enrollment when they transition between the CCC Plus Program and the Medallion 4.0 program without being enrolled in Fee-For-Service Medicaid. As above, continuity of care for transitions between Fee-For-Service and MCO's or between MCO's is 30 days.

The MEDALLION 4.0 and CCC+ programs have the same 6 (six) MCOs. Continuity of care for transitions between Fee-For-Service and MCO's or between MCO's is 30 days. The member's assigned MCO must honor any Fee-For-Service authorizations for up to 30 days.

Section A: Program Description

Part III: Quality

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

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

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

☑ 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:
12/08/17 *(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	HSAG		Validation of Performance Measures Validation of Performance Improvement Projects Administrative Compliance Assessment	Consumer Satisfaction Surveys Focused Surveys Encounter Data Validation
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:

☐ 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:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

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. [x] The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

3. [x] The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

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 5 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: 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):

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. ☑ The languages spoken by approximately 5.00 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.

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:

- [x] the State
- [x] 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:
Medicaid Expansion Population Initial Enrollment Notice:
The Department will send a notice to Medicaid expansion Populations at least sixty (60) days in advance of the open enrollment period notifying them of their right to change health plans at least annually. All Medicaid expansion Populations known to the Department will receive their initial enrollment letter on or before October 1, 2018.

Medicaid Expansion Population Notice of Action Letter:
On or before November 19, 2018, a Notice of Action letter will be sent to all Medicaid expansion populations known to the Department. The Notice of Action letter is an indication to the Member that he or she is now updated in the data systems as a Medicaid expansion population group.

Medicaid Expansion Population Medicaid ID Letter:
On or before December 19, 2018, a Medicaid ID letter will be sent to all Medicaid expansion populations known to the Department.

Medicaid Expansion Population Health Plan Assignment Letter:
Between December 21, 2018 and December 28, 2018 a Health Plan Assignment letter will be sent to all Medicaid expansion populations known to the Department. The Health Plan Assignment letter will indicate that the member has 90 days to switch health plans following the date of initial enrollment. The member will receive a MCO ID card and welcome packet no later than January 1, 2019.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

☑ 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:

DMAS is training advocates in government agencies, providers and provider associations, and higher education to provide information to individuals in their communities about the new health coverage options. Training will occur through webinars, presentations and an advocacy summit. Information will also be disseminated through social media, the Cover Virginia website and call center. Provider outreach will be conducted through meetings, conferences and electronic newsletters.

OUTREACH TO MEDICAID EXPANSION POPULATION

By November 1, 2018, the Contractor shall develop a specific outreach campaign for expansion enrollees which includes details on each of the following outreach activities for specific populations:

If the MCO offers a qualified health plan (QHP) certified by the Federal Health Insurance Marketplace under the Affordable Care Act, by November 1, 2018, the Contractor shall develop procedures for identifying those Members who are currently enrolled in the Contractor's QHP and who may qualify for Medicaid Expansion. The Contractor shall inform these Members in writing that they may qualify for Medicaid according to the marketing guidelines specified in this Contract. The MCO shall direct this population to the CoverVA call center or the local DSS to apply for Medicaid.

OUTREACH TO HOMELESS POPULATION
The MCO shall develop formal a referral and assistance processes and procedures in its existing care management programs that identify homeless members enrolled in the MCO's managed care program and provide them information and referrals to local shelters and other community based homeless aid programs and services provided in every region of the state. The MCO shall submit a report to DMAS annually that identifies these community based homeless support services by city/county, details of the formal referral relationships established, and how the MCO will make face to face contact with its homeless members.

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

Broker name: Maximus

Please list the functions that the contractor will perform:

- [x] choice counseling
- [x] enrollment
- [x] 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.):

- [x] 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.):

Coverage for the Medicaid Expansion population will be implemented on January 1, 2019 in all regions.

Individuals eligible through Medicaid expansion that are known to the Department, either because they were in a partial benefit plan (such as GAP or Family Planning), or who are determined to be Medicaid eligible prior to December 18, 2018, and who are Managed care eligible, will be enrolled with a MCO with an effective date as soon as January 1, 2019.

☑ 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 90 ◉ **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:

DMAS will use the following Enrollment process for the Medicaid expansion population:
1) For Members with an managed care case history, such as parents of children already enrolled in Medicaid the Department shall assign the parent to the same MCO with whom their dependent is enrolled.

2) For other individuals the Department will randomly assign each Member to a Contractor.

3) Members will have ninety (90) days from their initial MCO effective date to change their plan for any reason until the next expansion open enrollment period. A member can change their plan at any time with cause.

☑ 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 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

☐ The State does not have a **lock-in**, and enrollees in 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: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- [ ] The State seeks a waiver of 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:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- [x] The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

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 30 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:

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

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

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

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

   ☐ Has time frames for resolving requests for review.

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

   ☐ 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:

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:

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

- [x] The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- [x] State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
- [ ] The State seeks a waiver of 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:

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

Section 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:

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
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 ☐ 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
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 ☐ 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 ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☑ MCO ☐ PIHP	☑ MCO ☐ PIHP	☑ MCO ☐ PIHP

	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ 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 ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☑ MCO ☐ PIHP	☐ MCO ☐ PIHP	☑ MCO ☐ PIHP

	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ 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 ☐ 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 ☐ 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	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM

	☐ FFS	☐ FFS	☐ 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 ☐ 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	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM

	☐ FFS	☐ FFS	☐ 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 ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ 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
CCC+	MCO;

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: Commonwealth Coordinated Care Plus

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:

The Department has made a conscious decision to require its contracted health plans to attain and maintain NCQA accreditation status. As such, DMAS deems certain external quality review (EQR)-related activities (On-Site Reviews [Protocol 1] standards) that crosswalk to CMS requirements. There is some overlap between NCQA's quality standards the MCOs must meet to maintain accreditation and the three CMS-mandated quality activities performed by DMAS's contracted external quality review organization (EQRO). Figure 3, from the states quality strategy (http://www.dmas.virginia.gov/files/links/416/DMAS%202017-2019%20Quality%20Strategy.pdf), depicts from a snapshot of federally required EQR activities and the potential for duplication for each with NCQA accreditation standards. When overlaps between the federally required EQR activities and NCQA accreditation standards are clear, DMAS deems most of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the MCO meets the accreditation standards. The criteria for deeming is supported in 42 CFR §438.360 (non-duplication of mandatory activities). Although the performance measure validation activity seems duplicative of annual HEDIS audits experienced by the MCOs, it may not be deemed, according to CMS.

By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all NCQA health plan accreditation requirements and required reporting. Careful evaluation of quality and reporting requirements of NCQA allowed the Department to identify duplication of review efforts in some areas and through "deeming," these areas are now solely reviewed through the NCQA process. A prime example of this is the credentialing/re-credentialing standards for providers.

In order to maintain NCQA accreditation, NCQA conducts on-site reviews for each health plan every 3 years. During these reviews areas that are targeted include recipient choice, provider selection and capacity, availability of providers including PCPs and specialists, behavioral health, grievances/appeals, information to beneficiaries, coverage and authorization of covered services, and overall quality of care. health plans must also provide documentation to NCQA annually in order to maintain their status and adjust their rating, if warranted. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions, to include suspension, depending upon the reasons for denial by NCQA.

- [x] **NCQA**
- [ ] **JCAHO**
- [ ] **AAAHC**
- [ ] **Other**

Please describe:

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

Activity Details:

The Department has made a conscious decision to require its contracted health plans to attain and maintain NCQA accreditation status. By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all health plan accreditation requirements and required reporting. Careful evaluation of quality and reporting requirements of NCQA allowed the Department to identify duplication of review efforts in some areas and through "deeming," these areas are now solely reviewed through the NCQA process. A prime example of this is the credentialing/re-credentialing standards for providers.

In order to maintain NCQA accreditation, NCQA conducts on-site reviews for each health plan every 3 years. During these reviews areas that are targeted include recipient choice, provider selection and capacity, availability of providers including PCPs and specialists, behavioral health, grievances/appeals, information to beneficiaries, coverage and authorization of covered services, and overall quality of care. Health plans must also provide documentation to NCQA annually in order to maintain their status and adjust their

rating, if warranted. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions, to include suspension, depending upon the reasons for denial by NCQA.

- [x] **NCQA**
- [ ] **JCAHO**
- [ ] **AAAHC**
- [ ] **Other**

Please describe:

c. [x] **Consumer Self-Report data**

Activity Details:

One of the primary sources for consumer self-report data is use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both the adult and child populations. Each health plan will be required to conduct the CAHPS annually as a part of their NCQA requirements. The CAHPS survey is a useful tool to gauge customer satisfaction with their health plan and health providers. The survey poses direct questions to recipients regarding: provider selection and choice; timeliness and access to services; access to providers and specialists (including 24/7 availability of PCPs); coverage and authorization of services; ease of communications with providers; information provided to recipients; satisfaction with customer services; compliance with enrollee rights; coordination of care issues; and satisfaction with overall care/quality of care. The administration of an annual CAHPS survey allows each health plan to assess customer satisfaction with the services it provides and with provider network and availability, and assists the plan in identifying its strengths and weaknesses in order to continually improve on the quality of care provided to Virginia's managed care population.

In addition to CAHPS survey requirements, health plans will also be required to administer state specific member experience survey. This survey focus on areas not covered by CAHPS, including member experience with health plan care management, member quality of live, member experience with BH and LTSS services and supports.

Another means through which the Department monitors consumer self-report data is through contractually required appeals and grievance reports from each of the health plans and weekly complaint reports received from the Managed Care Helpline, some of which require intervention from Department staff. In addition to these formal required reports, the Department's Integrated Care and Behavioral Services (ICBS) division maintains an internal complaint database. This includes inquiries from providers, recipients, legislators and the general public. Items are entered into this database after being individually and personally addressed by division staff member. The database offers the Department the ability to run ad hoc reports which are useful in identifying patterns with issues in specific areas, with specific health planss, or with specific enrollees.

CCC+ Program health plans will be required to establish individual health plan Member Advisory Committee. These committees will be composed of CCC+ members and their representatives. Member experience and feedback will be gathered continuously as part of the Member Advisory Committee structure.

- [x] **CAHPS**

Please identify which one(s):

CAHPS Health Plan Survey 5.0H Adult Version
CAHPS Health Plan Survey 5.0H Child Version, Children With Chronic Conditions

- [x] **State-developed survey**
- [ ] **Disenrollment survey**
- [x] **Consumer/beneficiary focus group**

d. [x] **Data Analysis (non-claims)**

Activity Details:

Non-claim data analyses are conducted by the Department, contracted health plans, the

EQRO, and the enrollment broker. Each entity provides reports used in overall program monitoring. Enrollment data will be tracked and trended through various dashboards. Performance data including performance measure reporting data and survey data will be entered in our performance data to be tracked and trended. PCP termination rate will be tracked and monitored by each health plan. Other key none-claim data we will track and analyze to support program planning and operation will include authorization data and provider network data.

As part of NCQA requirements, the health plans will be required to perform all HEDIS measures that meet the minimum criteria for calculation. The health plan is to follow the most current version of Medicaid HEDIS technical specifications and discontinue measures as they are retired. NCQA also requires that each health plan HEDIS scores be audited by an external audit firm as approved by NCQA, before the scores can be submitted and accepted. Annual HEDIS measures, by health plan, can be found on the NCQA Quality Compass. health plans will also be required to track none HEDIS behavioral health measures and LTSS measures. Measure selection will be driven by the goals and objective of CCC + Program and align with Federal and state health care priorities. Ongoing performance measure trending will be conducted for CCC+. The Department will require corrective action plans for those measures below Department established benchmarks. A subset of the CCC+ program measures will be designated as key performance indicators. These indicators will be the main focus of quality improvement efforts. They will also inform us on CCC+ value based payment program measures selection.

The EQRO reports annually on their evaluations of the health plans' performance measures and performance improvement projects, and conducts a comprehensive operational systems review (OSR) on-site every three years as required by CMS. The Department will follow CMS requirements for managed care programs and utilize an EQRO and conduct an Operational Systems Review (OSR) every three years. These reviews will focus on, but not be limited to: provider licensure, insurance and other legal requirements; credentialing of providers; confidentiality and security; medical records content/retention; enrollee education/prevention programs; cultural competency; enrollment/disenrollment timeliness; grievances and appeals; network monitoring reports; coordination and continuation of care; quality assurance plan; health plan accreditation and audit; consumer and provider survey reports. In the years when there is not a scheduled OSR by the EQRO, DMAS may convene a team of internal subject matter experts to perform a “modified" OSR of each health plan in the form of a desk review and onsite audit. These reviews focus on any elements identified in the most recent (EQRO) OSR as needing improvement, or any critical elements of the health plan contract which require more focused attention. The Department also reserves the right to conduct on-site visits as a part of readiness reviews for program start up, when a new health plan is coming into the market, or there is an expansion into a region. The health plans are required to conduct performance improvement projects (PIPs) in accordance with 42 C.F.R. § 438.240(a)(2) and in focus areas as directed by the Department. Because most of the CCC+ population will be elderly and/or dual eligible it is likely the PIPs will focus on aspects of quality of care for these cohorts. Performance measures are a key feature in measuring a health plan's quality of care. They are an important part of the OSR review and other evaluations conducted by the EQRO. To meet the CMS requirement of EQR validation of performance measures, the EQRO validates a select group of health plan performance measure scores on an annual basis. Focused studies will be conducted annually by the EQRO and used to research, in depth, certain aspects of clinical or non-clinical services. The Department will develop specific areas of study based on the CCC+ Program population. Because most of the CCC+ population will be elderly and/or dual eligible it is likely the EQRO review will focus on aspects of quality of care for these cohorts. The EQRO will follow the CMS-recommended protocols for focused studies.

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

Please describe:

The Department defines the following reporting time-frames for CCC+ Contractors: 1. Prior to signing the original contract, upon revision, or upon request; 2. Semi-Annually and Annually; 3. Quarterly; 4. Monthly; and 5. Miscellaneous. DMAS is still trying to finalize the CCC+ Reporting Technical Manual which will include all reporting requirements. Here is a sampling of the requirements are as follows:

Prior to Signing Original Contract/Upon Revision*/Upon Request/As Needed:
(*Contracts are revised and signed annually. Asterisk indicates also required annually.)

*NCQA Accreditation Information
* Disclosure of Ownership and Control Interest
*Quality Improvement Program (QIP)
*Utilization Management Plan
Member Information Packets
Enrollment/disenrollment/educational materials made available to CCC+ members
Health Education and Prevention Plans and related member materials
Formulary and pre-authorization requirements
Written Policies and Procedures to cover multiple areas (For example, PCP/provider access and referrals, member rights, medical record confidentiality, security and access, EPSDT secondary reviews, prevention, detection, and reporting of potential fraud, waste, and abuse (provider and recipient), etc.)

Annually:
Bureau of Insurance (BOI) Annual Financial Report and any changes
Marketing Plan
Submission of Handbooks and letter identifying any changes
Physician Incentive Plans
HEDIS Information
Quality Improvement Plan
Prior Year's Outcomes (HEDIS, performance measures, quality studies, etc.)
MCO Organization Chart
Program Integrity Plan
Program Integrity Compliance Audit
Annual Audit Report (required by BOI)
CCC+ Core Performance Measures at annual reporting frequency

Quarterly:
BOI Quarterly Financial Report and any revisions
Provider Network File (also submitted to the enrollment broker monthly)
Providers Who Have Failed Credentialing/Recredentialing or have been denied application
Abuse, Corrective Action, Overpayment/Recovery Report
CCC+ Core Performance Measures at Quarterly reporting frequency

Monthly:
Provider and Member Grievances and Appeals Summary
Encounter Data Certification
Other Coverage Report
Comprehensive Health Coverage
Estate Recoveries
Monies recovered by Third Party
CCC+ Core Performance Measures at monthly reporting frequency

e. ☑ **Enrollee Hotlines**

Activity Details:
The Department will contract with an enrollment broker that will operate an enrollee hotline (aka the Helpline). This will be a key component in the monitoring process for both the State and the contracted health plans. The Managed Care Helpline will be the primary contact for all managed care participants on or after their assignment into managed care. This is likely the first point of contact for members during their health plan initial assignment phase. Enrollment broker staff will be able to answer questions about the

program, and provide information to members about providers in each health plan's network, enrollment/disenrollment processes, covered services, and exemption reasons. Issues which the helpline is not able to address, or which are beyond their scope, are referred to DMAS.

The enrollment broker will provide DMAS with a complaint report of issues identified during their contacts with members (for example, if a member is unable to obtain a needed service or medication, if they request a good cause change in health plan assignment outside of their open enrollment period, if they have not received an ID card from their health plan, etc.).

Enrollment broker staff will also develop and maintain the non-interactive website which will provide comprehensive and up-to-date information on Virginia's CCC+ program. Website activity, as well as call volume activity, and wait/hold times, will be reported to the Department monthly. The enrollment broker will have an optional satisfaction survey associated with their call script. members who opt to participate through an interactive voice response system complete five questions related to responsiveness, timeliness, and overall satisfaction with the helpline's services.

DMAS also operates two helplines for the fee-for-service population, one for recipients AND one for providers to answer questions, assist with billing issues, etc. This helpline may also receive calls from CCC+ Program participants.

The Department also maintains an email account (VAMLTSS@dmas.virginia.gov) solely for CCC+ Program questions, and will have designated staff at DMAS available to assist CCC+ Program potential enrollees and enrollees with program-related questions and issues.

The types of questions and issues presented to the helplines or received through other venues by Department staff allow for identification of patterns or problem areas which can then be targeted for improvements.

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:

Focused studies will be conducted annually by the EQRO and used to research, in depth, certain aspects of clinical or non-clinical services. The Department will develop specific areas of study based on the CCC+ Program population. Because most of the CCC+ population will be elderly and/or dual eligible it is likely the EQRO review will focus on aspects of quality of care for these cohorts. The EQRO will follow the CMS-recommended protocols for focused studies and uses the HEDIS measures when appropriate.

g. ☑ **Geographic mapping**

Activity Details:

The Department has "geomapping" capability. This will be used to establish network adequacy (including long-term care provider networks) prior to implementation of the CCC+ program as well as intermittently if questions about network adequacy arise or when there are complaints or grievances regarding access to services or specialties in specific areas.

Each of the health plans will also have "geomapping" capability (or a comparable software) and may use this when there are complaints regarding provider access in a specific area or with a specialty. The health plans submit their networks monthly to the enrollment broker and quarterly and as requested to the Department.

h. ☑ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

An independent assessment for the CCC+ Program will be conducted as required by CMS and the contract. This study will be in addition to the evaluations conducted by the EQRO and will cover various aspects of the program, with emphasis on access to care, quality of care, cost effectiveness, care coordination, and health and safety issues of the participants.

Program evaluations will also monitor the §1915(c) waiver requirements and coordination efforts between the two waivers with the goal of optimal outcomes for the CCC+ Program population.

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

Activity Details:
Each health plan is required to meet anti-discrimination standards as defined by CMS. If DMAS receives complaints of disparities or discrimination through our various channels of communication DMS staff has the ability to audit the plan and require any action necessary to correct the issue.

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

Activity Details:
Health plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for all Medicaid covered services. The State will monitor minimum LTSS and community behavioral health network requirements via an in-depth analysis of the submitted networks.

The contracted health plans will be required to provide DMAS with changes to their network on a quarterly and as-needed basis, and to the enrollment broker on a monthly basis. The health plans are contractually required to list in their provider directories languages spoken by the provider and if a provider is not accepting new clients. All the health plans also have websites which can be accessed by enrollees.

Comparison charts, which are updated annually at open enrollment, and as needed, are provided to enrollees with their pre-assignment letters to help them when making a choice of health plans. These charts identify the health plans in each locality, local hospitals with which each health plan contracts, and extra programs and services offered by each MCO.

Network analyses and complaint tracking are just two ways that access to care is monitored and ensured.

k. ☑ **Ombudsman**

Activity Details:
As part of its efforts to educate members about the CCC+ Program, and to ensure that their rights are protected, DMAS has continued its partnership with the Virginia Insurance Counseling Program (VICAP) and the State Long-Term Care (LTC) Ombudsman. Under this partnership, VICAP is responsible for providing dual eligible (Medicare and Medicaid beneficiaries (and their families)) with unbiased educational information about their options for participating in CCC+, while the LTC Ombudsman is responsible for protecting all beneficiaries rights, investigating complaints, empowering beneficiaries to resolve health care problems, and assisting with appeals and grievances for members receiving long term care services.

l. ☑ **On-Site Review**

Activity Details:
The Department will follow CMS requirements for managed care programs and utilize an EQRO and conduct an Operational Systems Review (OSR) every three years. These reviews will focus on, but not be limited to: provider licensure, insurance and other legal requirements; credentialing of providers; confidentiality and security; medical records content/retention; member education/prevention programs; cultural competency; enrollment/disenrollment timeliness; grievances and appeals; network monitoring reports; coordination and continuation of care; quality assurance plan; health plan accreditation and audit; consumer and provider survey reports.

In the years when there is not a scheduled OSR by the EQRO, DMAS may convene a team of internal subject matter experts to perform a “modified" OSR of each health plan. These reviews focus on any elements identified in the most recent (EQRO) OSR as needing improvement, or any critical elements of the health plan contract which require more focused attention.

The Department also reserves the right to conduct on-site visits as a part of readiness reviews for program start up, when a new health plan is coming into the market, or there is an expansion into a region.

The Department will conduct readiness review(s) which will include desk reviews and site visits. The purpose of the review is to provide the Department with assurances that the health plan is able and prepared to perform all administrative functions and to provide high-quality services to enrollees. No individual shall be enrolled into the health plan prior to the Department making a determination that the health plan is ready and able to perform its obligations under the contract as demonstrated during the readiness review. Readiness reviews, including on-site reviews, are tentatively scheduled to be completed January through April of 2017.

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

Activity Details:
The health plans are required to conduct performance improvement projects (PIPs) in accordance with 42 C.F.R. § 438.240(a)(2) and in focus areas as directed by the Department. Because most of the CCC+ population will be elderly and/or dual eligible it is likely the PIPs will focus on aspects of quality of care for these cohorts.

DMAS MCO contracts require MCOs to measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance improvement projects (PIPs) is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. DMAS requires that contracted Medicaid MCOs conduct PIPs in accordance with 42 CFR §438.330 (d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction. The PIP design requires use of objective quality indicators, implementation of interventions to improve access and quality, evaluation of effectiveness, and activities for increasing or sustaining improvements.

☑ **Clinical**

☑ **Non-clinical**

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

Activity Details:
Performance measures are a key feature in measuring a health plan's quality of care. They are an important part of the OSR review and other evaluations conducted by the EQRO. To meet the CMS requirement of EQR validation of performance measures, the EQRO validates a select group of health plans HEDIS scores on an annual basis.

As part of NCQA requirements, the HEALTH PLANs will be required to perform all HEDIS measures that meet the minimum criteria for calculation. The HEALTH PLAN is to follow the most current version of Medicaid HEDIS technical specifications and discontinue measures as they are retired. NCQA also requires that each HEALTH PLAN'S's HEDIS scores be audited by an external audit firm as approved by NCQA, before the scores can be submitted and accepted. Annual HEDIS measures, by health plan, can be found on the NCQA Quality Compass.

DMAS has identified clinical quality, access, and utilization measures for the CCC Plus and Medallion 4.0 programs using the nationally recognized measure sets. DMAS will select a subset of HEDIS measures for tracking and trending HEALTH PLAN performance and to set benchmarks for improving the health of the populations served through the managed care delivery system. The HEDIS measures that are a priority for continuous improvement are selected based on the needs of the populations served and the favorable health outcomes that result when the relevant clinical guidelines are adhered to by each HEALTH PLAN'S's provider network.

The Department will require corrective action plans for those measures below the identified percentile (nationally). HEDIS score ratings and corrective action plans will be closely monitored by the Department's Quality Assurance staff.

In addition to the HEDIS measures discussed above, DMAS will also require the health plans to track measures focusing on Long Term Services and Support, non-traditional behavioral health services, and care management and care coordination. These measures will come from the Core Performance Measures List. To meet the CMS requirement of EQR validation of performance measures, DMAS will select a group of measure each year for our EQRO to validate.

The Department will also require the health plan to conduct quality improvement projects or corrective action plans for any measures below the DMAS identified performance measure benchmarks. These improvement projects and corrective action plans will be closely monitored by DMAS' quality assurance staff. In addition, both performance measure reporting data quality and quality of care performance will be used as measure for CCC+ value-based payment program.

The measures listed in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the populations (e.g., CCC Plus versus Medallion 4.0), DMAS takes into consideration the availability and reliability of the data that are used to calculate the measures.
The Contractor's reporting of quality performance measures shall at minimum cover the following four (4) domains:
1) Enhance Member experience and engagement in person-centered care;
2) Improve quality of care;
3) Improve population health; and,
4) Reduce per capita costs.

Within these four (4) domains, the Department has identified five (5) priority areas and selected measures that align with Federal, State and CCC Plus quality improvement aims and priorities.

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

o. [x] **Periodic Comparison of # of Providers**

Activity Details:
The health plans will be required to continually monitor their networks to ensure adequate coverage of all provider types within required CMS and state guidelines. In accordance with 42 CFR § 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:
• Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
• Consider the needs of the members;
• Are adopted in consultation with contracting health care professionals; and,
• Are reviewed and updated periodically, as appropriate.

The HEALTH PLAN networks will be submitted to the enrollment broker monthly and to the Department quarterly or as requested, especially during start up, expansions or when plans are withdrawing from certain areas. HEALTH PLAN providers will be required to "register" with by the Department and will be encouraged, though not required, to enroll as Virginia Medicaid providers.

The Department has "geomapping" capability and is able to conduct provider analyses as needed, when there is a question or complaint about access. There were no noted access issues during the previous waiver period.

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

Activity Details:
The MCOs will be required by contract and through the most current NCQA standards to have a written utilization management (UM) program which includes procedures to evaluate medical necessity, criteria used, information source and the process used to review and approve or deny the provision of medical services. The UM program must ensure consistent application of review criteria, and must demonstrate that members have equitable access to care across the network and that UM decisions are made in a fair, consistent, impartial manner that serves the best interests of the members. The program must have mechanisms to detect under-utilization and /or over-utilization of care including, but not limited to provider profiles.

The health plans will be required to submit reports to Department staff on a quarterly basis regarding providers who have failed credentialing/re-credentialing. The MCO's also submit to the Department a quarterly report of abuse, corrective action, overpayment/recovery. This data is shared with the Department's Program Integrity Division for potential provider monitoring activities.

q. ☑ **Provider Self-Report Data**

Activity Details:
Provider self-report data is conducted annually by the health plans as a part of their NCQA requirements.

☑ **Survey of providers**

☐ **Focus groups**

r. ☑ **Test 24/7 PCP Availability**

Activity Details:
As a part of the Contract requirements and as required by NCQA the health plans must maintain adequate provider network coverage to serve the entire eligible CCC+ population in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days/week (24/7). This coverage requirement is monitored through the CAHPS survey questions, as well as during the EQRO's evaluations and on-site visits.

In addition to the 24/7 PCP availability requirement, the health plans will be contractually required to provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist members. Recipients will be provided with information regarding access to and use of the nurse line and are encouraged to call the nurse line after hours for questions or concerns. Recipients who contact these nurse lines will be provided with treatment advice, or are advised to seek immediate attention through the Emergency Room. Use of the nurse lines not only provides peace of mind for the plan's member population, but is seen as a mechanism to divert inappropriate emergency room utilization.

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

Activity Details:
Utilization review for CCC+ Program beneficiaries will be conducted by each health plan and is used to determine appropriate use of referrals, authorizations, etc. The plans will look at both over-and under-utilization as well as referral and authorization patterns. The contract will require health plans to operate a Pharmacy Utilization Management Program. The need for this was identified through rising costs and the ability to track abuse of certain recipients, or certain medications.

The health plans are permitted to operate a Physician Incentive Plan only if: No single physician is put at financial risk for the costs of treating an member that are outside the physician's direct control; No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to a member; and The applicable stop/loss protection, member survey, and disclosure requirements of 42 C.F.R. Part 417 are met. Contractually, the plans will be prohibited from making any payments under a Physician Incentive Plan as an inducement to limit or reduce medically necessary services to a recipient.

DMAS staff will monitor appropriate utilization through complaints/complaint logs, grievances and appeals, and corresponding monthly or quarterly reports. DMAS will also conduct secret shopper, satisfaction surveys and on site reviews of the health plan records.

t. ☑ **Other**

Activity Details:
Building off of what was established with CCC, the Department, the health plans, EQRO, other state agencies, and stakeholders will conduct on-going monitoring activities to ensure compliance to managed care program requirements and the provision of quality of care for all CCC+ members. Monitoring mechanisms will include but not be limited to: frequent meetings or conference calls; evaluation of complaint and other required reports; Good Cause requests; Program Integrity audits; EQRO reviews; information provided to recipients through mailings or that is available on the DMAS/Managed Care websites; and information provided by the enrollment broker and DMAS helplines. This continual monitoring will be done to meet federal and state regulatory compliance, and to fulfill the DMAS managed care goal which is, "to provide a cost-effective managed care delivery system for eligible Medicaid members that exceeds the industry standards for timeliness, access and quality of care."

The Department prides itself on the open communication with our health plan partners and their willingness towards collaboration (e.g. in areas of Program Integrity, Quality, or expansions). From experience within other programs we've found that the health plans as a group readily participate with the Department in formal and ad hoc workgroup meetings and in individual plan meetings. Many of our current health plan partners have also participated in the Virginia Health Reform Initiative (VHRI) Center committees, and are always open to discussions with the Department and other entities (e.g. the Health Department or Department of Behavioral Health and Development Services) regarding service needs of the population, ideas for new programs, and identified target areas for improvement. DMAS expects the health plans contracting for the CCC+ Program will do the same.

We continue to seek opportunities to improve access and quality of services through mechanisms such as Behavioral Health Homes, Patient Centered Medical Homes and Value Based Purchasing. Our plans share the goal of accessible and quality health care services for residents of the Commonwealth and are always willing to entertain new ideas and approaches to collaboratively meet this goal.

The close monitoring efforts and hands-on attention to individual complaints allows the Department to identify potential problem areas, patterns or trends in the type of problems, and whether the problems stem from programmatic issues, which may be corrected or addressed through clarification memos or contract amendments.

Section C: Monitoring Results

Initial 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 an Initial waiver request.

☑ **The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title
Nursing Home Eligible Institutional (NHE I) - Duals
Nursing Home Eligible Institutional (NHE I) - Non Duals
Consumer Directed Waivers (EDCD) - Duals
Consumer Directed Waivers (EDCD) - Non Duals
ID/DD Waivers - Duals
ID/DD Waivers - Non Duals
Technology Assisted Waiver
Community No LTSS (No Level of Care) - Duals
Community No LTSS (No Level of Care) - Non Duals
MedExp Childless Adults
MedExp Caretaker

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2015	12/31/2015		
Enrollment Projections for the Time Period*	07/01/2017	06/30/2018	07/01/2018	06/30/2019

**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	
Abortions	☑	☐	☑	
Case Management Services	☑	☐	☑	
Community Health Centers	☑	☐	☑	
Clinic Services	☑	☐	☑	
Community Mental Health	☑	☐	☑	
Community Mental Retardation	☑	☐	☑	
Day Treatment for Pregnant Women	☑	☐	☑	
Dental Services (<21 YO)*	☑	☐	☐	
Durable Medical Equipment	☑	☐	☑	
Early Intervention				

	☑	☐	☑
EPSDT Screening, Diagnosis and Treatment	☑	☐	☑
Family Planning	☑	☐	☑
Federally Qualified Health Center	☑	☐	☑
Home Health Services	☑	☐	☑
Immunizations	☑	☐	☑
Inpatient Hospital (includes psych except for State Psychiatric Hospital)	☑	☐	☑
Lab and Radiology	☑	☐	☑
Lead Investigations	☑	☐	☐
Nurse Midwife	☑	☐	☑
Nursing Facility	☑	☐	☑
Other Rehabillitation Services	☑	☐	☑
Outpatient Hospital (includes psych)	☑	☐	☑
Personal Care	☐	☐	☑
Physician Services (includes psych)	☑	☐	☑
Podiatry	☑	☐	☑
Prescribed Drugs, Prosthetic Devices and Eyeglasses	☑	☐	☑
Private Duty Nursing	☐	☐	☑
PT, OT, Speech, Audiology Services	☑	☐	☑
Regular Assisted Living	☑	☐	☑
Residental Treatment	☑	☐	☐
Respite Care	☐	☐	☑
Rural Health Clinic	☑	☐	☑
School-based Services	☑	☐	☐
Sterilizations	☑	☐	☑
Substance Abuse	☑	☐	☑
Targeted Case Management to SMI/ED/MR	☑	☐	☑
Temporary Detention Orders	☑	☐	☑
Transplants	☑	☐	☑
Vision Services	☑	☐	☑
Services Facilitation	☐	☐	☑
Personal Emergency Response System (PERS)	☐	☐	☑
Transition Coordination	☐	☐	☑
Transition Services	☐	☐	☑
Assistive Technologies	☐	☐	☑

Environmental Modifications	☐	☐	☑
Private Duty Nursing (non EPSDT)	☐	☐	☑
Group Day Services	☐	☐	☐
In-home Support Services	☐	☐	☐
Individual Supported Employment	☐	☐	☐
Participant Direction Services Facilitation	☐	☐	☐
Center-based Crisis Supports	☐	☐	☐
Community Coaching	☐	☐	☐
Community Engagement	☐	☐	☐
Community-based Crisis Supports	☐	☐	☐
Companion Services	☐	☐	☐
Crisis Support Services	☐	☐	☐
Electronic Home-based Supports	☐	☐	☐
Group Supported Employment	☐	☐	☐
Individual and Family Caregiver Training	☐	☐	☐
Shared Living	☐	☐	☐
Skilled Nursing	☐	☐	☐
Supported Living Residential	☐	☐	☐
Therapeutic Consultation	☐	☐	☐
Workplace Assistance	☐	☐	☐
Group Home Residential	☐	☐	☐
Transportation	☑	☐	☑
	☐	☐	☑
Individual and Group Smoking Cessation Counseling	☐	☐	☑
Nutritional Counseling for Individuals with Obesity or Chronic Medical Diseases	☐	☐	☑
Vaccines or Immunization	☐	☐	☑
Annual Adult Wellness Exams	☐	☐	☑

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:	Jennifer Lee
	State Medicaid Director or Designee
Submission Date:	Nov 7, 2018
	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:

Nick Merciez

c. Telephone Number:

(804) 225-4269

d. E-mail:

Nick.Merciez@dmas.virginia.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

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.** [x] **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. ☑ Population in the base year data

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

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

c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
CCC Plus Enrollment in the first projection year reflects transitional enrollment by region in 2017 by MEGS - NHE IDual,NHE INon-Dual,EDCD Waivers Dual,EDCD Waivers Non-Dual,ID/DD Waivers Dual, ID/DD Waivers Non-Dual, Technology Assisted Waiver, No Level of Care Dual,No Level of Care - Non-Dual. Enrollment thereafter is projected to increase or remain constant due to population aging and the addition of enrollment slots in the combined ID/DD waiver.
CCC Dual Demonstration and ABD Population from Med 3.0 moved to CCC Plus in Jan 2018 and are aligned to existing MEGS. Medically complex groups namely Childless Adults and Caretaker population MEGS will be enrolled into CCC Plus as part of Medicaid Expansion in Jan,2019.

d. [Required] Explain any other variance in eligible member months from BY to P2:
Projected enrollment was modeled using time series analysis of historical member months by MEG in the base period adjusted to reflect CCC Plus Medicaid expansion implementation. The variance is due to continued enrollment and increase in membership for the existing MEGS, inclusion of limited benefit GAP population, Plan first population and newly eligible population that are medically complex in Medicaid expansion.

e. [Required] List the year(s) being used by the State as a base year:
2015
If multiple years are being used, please explain:

f. [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
Calendar year 2015

g. [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

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.

Appendix D2.S: Services in Waiver Cost

State Plan	MCO Capitated	FFS Reimbursement impacted by	PCCM FFS	PIHP Capitated	FFS Reimbursement impacted by	PAHP Capitated	FFS Reimbursement impacted by

Services	Reimbursement	MCO	Reimbursement	Reimbursement	PIHP	Reimbursement	PAHP
Abortions	☐	☐	☐	☐	☐	☐	☐
Case Management Services	☑	☐	☐	☐	☐	☐	☐
Community Health Centers	☑	☐	☐	☐	☐	☐	☐
Clinic Services	☑	☐	☐	☐	☐	☐	☐
Community Mental Health	☑	☐	☐	☐	☐	☐	☐
Community Mental Retardation	☐	☑	☐	☐	☐	☐	☐
Day Treatment for Pregnant Women	☐	☑	☐	☐	☐	☐	☐
Dental Services (<21 YO)*	☐	☑	☐	☐	☐	☐	☐
Durable Medical Equipment	☑	☐	☐	☐	☐	☐	☐
Early Intervention	☑	☐	☐	☐	☐	☐	☐
EPSDT Screening, Diagnosis and Treatment	☑	☐	☐	☐	☐	☐	☐
Family Planning	☑	☐	☐	☐	☐	☐	☐
Federally Qualified Health Center	☑	☐	☐	☐	☐	☐	☐
Home Health Services	☑	☐	☐	☐	☐	☐	☐
Immunizations	☑	☐	☐	☐	☐	☐	☐
Inpatient Hospital (includes psych except for State Psychiatric Hospital)	☑	☐	☐	☐	☐	☐	☐
Lab and Radiology	☑	☐	☐	☐	☐	☐	☐
Lead Investigations	☐	☐	☐	☐	☐	☐	☐
Nurse Midwife	☑	☐	☐	☐	☐	☐	☐
Nursing Facility	☑	☐	☐	☐	☐	☐	☐
Other Rehabillitation Services	☑	☐	☐	☐	☐	☐	☐
Outpatient Hospital (includes psych)	☑	☐	☐	☐	☐	☐	☐

Personal Care	☑	☐	☐	☐	☐	☐	☐
Physician Services (includes psych)	☑	☐	☐	☐	☐	☐	☐
Podiatry	☑	☐	☐	☐	☐	☐	☐
Prescribed Drugs, Prosthetic Devices and Eyeglasses	☑	☐	☐	☐	☐	☐	☐
Private Duty Nursing	☑	☐	☐	☐	☐	☐	☐
PT, OT, Speech, Audiology Services	☑	☐	☐	☐	☐	☐	☐
Regular Assisted Living	☑	☐	☐	☐	☐	☐	☐
Residental Treatment	☐	☑	☐	☐	☐	☐	☐
Respite Care	☑	☐	☐	☐	☐	☐	☐
Rural Health Clinic	☑	☐	☐	☐	☐	☐	☐
School-based Services	☐	☑	☐	☐	☐	☐	☐
Sterilizations	☑	☐	☐	☐	☐	☐	☐
Substance Abuse	☑	☐	☐	☐	☐	☐	☐
Targeted Case Management to SMI/ED/MR	☑	☐	☐	☐	☐	☐	☐
Temporary Detention Orders	☐	☑	☐	☐	☐	☐	☐
Transplants	☑	☐	☐	☐	☐	☐	☐
Vision Services	☑	☐	☐	☐	☐	☐	☐
Services Facilitation	☐	☑	☐	☐	☐	☐	☐
Personal Emergency Response System (PERS)	☐	☑	☐	☐	☐	☐	☐
Transition Coordination	☐	☑	☐	☐	☐	☐	☐
Transition Services	☐	☑	☐	☐	☐	☐	☐
Assistive Technologies	☐	☑	☐	☐	☐	☐	☐
Environmental Modifications	☐	☑	☐	☐	☐	☐	☐
Private Duty							

Nursing (non EPSDT)	☐	☑	☐	☐	☐	☐	☐
Group Day Services	☐	☑	☐	☐	☐	☐	☐
In-home Support Services	☐	☑	☐	☐	☐	☐	☐
Individual Supported Employment	☐	☑	☐	☐	☐	☐	☐
Participant Direction Services Facilitation	☐	☑	☐	☐	☐	☐	☐
Center-based Crisis Supports	☐	☑	☐	☐	☐	☐	☐
Community Coaching	☐	☑	☐	☐	☐	☐	☐
Community Engagement	☐	☑	☐	☐	☐	☐	☐
Community-based Crisis Supports	☐	☑	☐	☐	☐	☐	☐
Companion Services	☐	☑	☐	☐	☐	☐	☐
Crisis Support Services	☐	☑	☐	☐	☐	☐	☐
Electronic Home-based Supports	☐	☑	☐	☐	☐	☐	☐
Group Supported Employment	☐	☑	☐	☐	☐	☐	☐
Individual and Family Caregiver Training	☐	☑	☐	☐	☐	☐	☐
Shared Living	☐	☑	☐	☐	☐	☐	☐
Skilled Nursing	☐	☑	☐	☐	☐	☐	☐
Supported Living Residential	☐	☑	☐	☐	☐	☐	☐
Therapeutic Consultation	☐	☑	☐	☐	☐	☐	☐
Workplace Assistance	☐	☑	☐	☐	☐	☐	☐
Group Home Residential	☐	☑	☐	☐	☐	☐	☐
Transportation	☑	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
Individual and Group Smoking Cessation Counseling	☑	☐	☐	☐	☐	☐	☐

Nutritional Counseling for Individuals with Obesity or Chronic Medical Diseases	☑	☐	☐	☐	☐	☐	☐
Vaccines or Immunization	☑	☐	☐	☐	☐	☐	☐
Annual Adult Wellness Exams	☑	☐	☐	☐	☐	☐	☐

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:

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

  Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

- ☐ 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.
- ☐ **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:

- ☑ **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:

The State provides prescription drug reinsurance coverage. The coverage applies to members with prescription drug claims in excess of $175,000 in a calendar year. The State pays 90% of claims in excess of $175,000. In CY17, the coverage was paid for by a reduction in the capitation that would otherwise be paid. Beginning in CY18, we created a budget neutral reinsurance pool between plans.

. ☑ **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.**

There are no incentive arrangements applied to the rates in CY 2017.
1% of capitation payments is withheld as Quality withholds in CY2018 and CY2019 from all the CCC Plus population MEGS.
Medicaid expansion population is also subject to quality withholds.
MCO Plans earn back these quality withhold amounts as they meet quality measures set by DMAS.

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)

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in

order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

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

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

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

The actual trend rate used is:

2.80

Please document how that trend was calculated:

DMAS obtained the services from a Certified Actuary to establish trends using a least-squares regression methodology.

Historical data for CY 2015 to CY 2016, with run out through Feb 2018, are used to evaluate the base period trend.Trend was developed for each Medicaid Eligibility Groups (MEG) for CCC + - NHE I Duals and Non Duals, Consumer Directed Waiver (EDCD) Duals and Non Duals , ID/DD Waiver Duals and Non Duals, Tech Waiver State wide, Community No LTSS (No Level Of Care) Duals and Non Duals and service categories.

The MEG service categories are Inpatient, Outpatient/ER/Ancillary/Other, Professional, Pharmacy, Nursing Facility, HCBS/Home Health Services, Mental Health/Substance Abuse for Dual and Non Dual groups along with Medicare Xover for Duals. For larger CCC + groups, Dual and Non Dual NHE I, EDCD and Community No LTSS, trend and IBNR factors are developed separately for the service categories. For the Dual populations, the Medicare Xover trend is calculated separately and combines all services where Medicare is the primary payer. For small CCC + groups, both Dual and Non-Dual ID/DD and Tech Waivers, service categories are combined into an All Services trend. For Medallion 3.0 group moving to CCC +, the Non Dual EDCD and Non-Dual DD, acute care trend is developed into All Service acute care trend.

The service category trend relied upon analysis of historical DMAS FFS claims data and health plan encounter data for CY15 and CY16 with run out through Feb 2018.

Adjustments that are known to be effective July 1, 2018, are made to the historical base data to reflect the benefits and costs. The following Adjustments Hospital Inpatient,Outpatient,Nursing facility,Adult day care,Personal Care and Respite Care, DME fee,Hep C, Lab fee, ER Triage ,RBRVS rebasing ,Home Health and Rehab , Non-ER transportation , Managed Care Savings ,Prescription drug, reinsurance and ARTS are made to the portion of the base period prior to the implementation of each program change before determining the applied trend values. This was done to assure that program and policy adjustments were not duplicated in the trend adjustment.

Annual trend rates are applied to move the historical data from the midpoint of the data period (January 1, 2015) to the midpoint of the contract period (September 30, 2017). Each service category has a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work .The Contract Period trends are applied from the end of the data period to the weighted midpoint of the contract period. The weighted mid-point, April 1, 2019, was derived by using the projected member months for the CY 2019 implementation.

2. ☑ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated 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

CY2015-CY2016

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.
Contract period Projection period trend applied from R1 to P1 and P2 are developed based on an additional year of data, CY 2014 with run out through Feb 2018, to the base data CY2015 to CY2016. Overall, the methodology is similar to that used for the data period trend, except that an additional year of data is evaluated.
For all the CCC + MEGs(described above in I.a.1), trend is based on an evaluation of the historical trend of DMAS Fee for service paid claims data and health plan encounter data for the historical period CY15 and CY16 with run out through Feb 2018 and is calculated using a least squares regression methodology.
Annual trend rates are applied to move the historical data from the midpoint of the data period (January 1, 2015) to the midpoint of the contract period (September 30, 2017). Each service category has a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work described above. The Contract Period trends are applied from the end of the data period to the weighted midpoint of the contract period. The weighted mid-point, April 1, 2019, was derived by using the projected member months for the CY 2019 implementation.
For services with fee increases or decreases reflected in the adjustments, the contract period trend is in addition to the planned cost per unit change. Trend rates represent a combination of cost and utilization increases over time. The trend rates used reflect utilization and rate increases when additional legislative cost increases or decreases have been applied and represent PMPM increases otherwise. There is an exception for nursing facility where the trend reflects only the utilization changes over time.
Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period that are presented as adjustments. A number greater than 1 reflects an increase to bring up the underlying data to the level of the most recent period while a number less than 1 represents a decrease. Adjustments to the historical data before the analysis of trend were applied to service line trends.
The projected trends are also evaluated for reasonableness compared to trends that have been established for other state Medicaid managed care programs.
Contract trend factors estimated from the regression analysis are applied to the MEGS for the period P1 to P2. Capitation rates for CY19 are not final as of the date of this CE submission and trend rates remain under review.

ii. ☐ National or regional factors that are predictive of this waiver's future costs.

Please indicate the services and indicators used.

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

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

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

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

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)

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

Others:

- **Additional State Plan Services (+)**
- **Reductions in State Plan Services (-)**
- **Legislative or Court Mandated Changes to the Program Structure or fee**

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.

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

0.00

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

Approximate PMPM size of adjustment

0.00

C. ☐ Determine adjustment based on currently approved SPA.

PMPM size of adjustment

0.00

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

E. ☑ Other:

Please describe

Programmatic adjustments in CY2018 are A)inclusion of ABD and CCC members,B) inclusion of Community Mental Health Services C) State GA directed adjsts to few COS.

For CY2019,Maternity Kick Payments and directed payments for private acute care hospitals adjustments are made.For MedExp,Exp-elig Age Adjst,ABP Benefit Pkg Adjst,Acuity and Pent-up demand adjsts are made.

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:

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

Section D: Cost-Effectiveness

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

c. **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☑ An administrative adjustment was made.

i. ☑ FFS administrative functions will change in the period between the beginning of P1 and the end of P2.

Please describe

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

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

Please describe

C. ☑ Other

Please describe

The admin cost allocation method was changed to ensure that the method described in the waiver agrees with the cost allocation method described in the DMAS Cost Allocation Plan.

DMAS amended its cost allocation plan effective 1/1/2018 (DMAS CAP Amendment 18-01) to change the cost allocation method from one that allocates based on enrollment to one that allocates based on program costs.

ii. ☐ FFS cost increases were accounted for.

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

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

C. ☐ Other

Please describe

iii. ☑ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.
For CCC +,In P1 (7/1/2017-6/30/2018) administrative expenses projection is
8%
in P2 (7/1/2018-6/30/2019) administrative expenses projection is 5%
in P3 (7/1/2019-6/30/2020) administrative expenses projection is 4%
in P4 (7/1/2020-6/30/2021) administrative expenses projection is 4%
in P5 (7/1/2021-6/30/2022) administrative expenses projection is 4%

A. Actual State Administration costs trended forward at the State historical administration trend rate.

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

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.I.a. above
0.00

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

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

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:
0.00
Please provide documentation.

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

i. State Plan Service trend

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

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

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

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ☐ We assure CMS that GME payments are included from base year data.
2. ☐ We assure CMS that GME payments are included from the base year data using an adjustment.
   Please describe adjustment.
3. ☑ Other
   Please describe
   Graduate Medical Education are paid outside of the claims processing system and are not included in the base period FFS claims.

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

1. ☐ GME adjustment was made.
   - i. ☐ GME rates or payment method changed in the period between the end of the BY and the beginning of P1.
     Please describe
   - ii. ☐ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2.
     Please describe
2. ☐ No adjustment was necessary and no change is anticipated.

Method:

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

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

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

1. ☐ Payments outside of the MMIS were made.

Those payments include (please describe):

2. ☑ Recoupments outside of the MMIS were made.

Those recoupments include (please describe):
Pharmacy Rebates

3. ☐ The State had no recoupments/payments outside of the MMIS.

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

Basis and Method:

1. ☑ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2. ☐ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.

3. ☐ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.

4. ☐ Other

Please describe

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

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

2. ☐ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

***Method*:**

1. ☐ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).

2. ☐ Determine copayment adjustment based on pending SPA.

3. ☐ Determine copayment adjustment based on currently approved copayment SPA.

4. ☐ Other

Please describe

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

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

Basis and method:

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

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

***Basis and Method*:**

1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in Appendix D5.
   Please describe
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. ☑ Ohter
   Please describe
   A FFS rebate adjustment of 4% is used and MCO rebates equal to 1.9% of total pharmacy expenditures is used.

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. ☑ We assure CMS that DSH payments are excluded from base year data.
2. ☐ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ☐ Other

Please describe

l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. ☐ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. ☐ This adjustment was made:
   - i. ☐ Potential Selection bias was measured.
     Please describe
   - ii. ☐ The base year costs were adjusted.
     Please describe

m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ☑ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs.
   Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. ☐ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ☐ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. ☐ Other
   Please describe

Section D: Cost-Effectiveness

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

Special Note Section:

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

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

a. ☐ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and

is basing the cost-effectiveness projections on the remaining quarters of data.

b. ☑ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

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

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain capitated-only adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

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

n. ***Incomplete Data Adjustment (DOS within DOP only)*** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.:

1. ☐ Using the special DOS spreadsheets, the State is estimating DOS within DOP.

Incomplete data adjustments are reflected in the following manner on Appendix D5 for services to be complete and on Appendix D7 to create a 12-month DOS within DOP projection:

2. ☐ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3. ☐ Other

Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

1. ☐ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2. ☐ Other

Please describe

p. ***Other adjustments:*** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. ☑ No adjustment was made.
2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.

   Please describe

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

This section is only applicable to Renewals

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

This section is only applicable to Renewals

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

This section is only applicable to Renewals

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

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.

Please see attached/emailed Excel spreadsheets.
For CY 2019, Historical data for CY 2015 to CY 2016, with run out through Sep 2017, are used to evaluate the base period trend and an additional year of data, CY 2014 with run out through Feb 2018, is added to the base and used to develop contract period projected trend.
1. Trend was developed for each Medicaid Eligibility Groups (MEG) for CCC + -NHE I Dual and Non Dual, Consumer Directed Waiver Dual and Non Dual , ID/DD Waiver Dual and Non Dual, Technology Assisted Waiver State wide, Community No LTSS (No Level Of Care) Dual and Non Dual and the service categories.
2. Applied Program Adjustments that includes Physician directed payments and Drug Rebate Adjustments.
3. Applied Maternity Kick Payments and directed payments for private acute care hospitals adjustments.
4. Applied the administrative adjustment to the CCC+ MEG to the base periods and contracted projected periods.

For CY2019,For Medically complex Medicaid Expansion groups - MedExp Childless Adults, MedExp Caretaker - MedExp,Age band Adjsts,ABP Benefit Pkg Adjsts,Acuity and Pent-up demand adjsts are made.
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.

Please see attached/emailed Excel spreadsheets.
CCC + program population enrollment is in phases by region in CY 2017.
VA Tidewater region enrollment is on Jul 1,2017, Central VA - Sep 1,2017, Charlottesville/Western VA - Oct 1,2017, Roanoke/Alleghany and Southwest VA - Nov 1,2017 and Northern/Winchester VA ins in Dec 1,2017.

CY2018 - CCC duals demonstration and Medallion 3.0 Aged Blind Disabled are enrolled in Jan,2018.
The trend after the initial enrollment is based on the population growth and case mix between NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS groups.

CY2019 - Trends are calculated for NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS groups based on CY2015 and CY2016 with run out through Feb 2018.
Medicaid expansion newly eligible population is categorized into Medically complex MedExp Childless Adults and MedExp Caretaker MEGS.
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.

P2 Weighted Average PMPM Casemix for BY (BY MMs) - 0.6%
P2 Weighted Average PMPM Casemix for P2 (P2 MMs) - 0.6%

Overall BY to P2 Change (annualized)
NHE IDual - 4.0%
NHE INon-Dual - 5.4%
EDCD Waivers Dual - 3.9%

EDCD Waivers Non-Dual - 10.2%
ID/DD Waivers Dual - (-9.8%)
ID/DD WaiversNon-Dual - 4.5%
Technology Assisted Waiver - 2.0%
No Level of Care Dual - 4.9%
No Level of Care Non-Dual - 11.4%

The variance is because of the enrollment population growth and case mix between different Medicaid eligibility groups - NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS groups.

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:

   CY2017 - CCC + program population enrollment is in phases by region.
   VA Tidewater region enrollment is on Jul 1,2017, Central VA - Sep 1,2017, Charlottesville/Western VA - Oct 1,2017, Roanoke/Alleghany and Southwest VA - Nov 1,2017 and Northern/Winchester VA ins in Dec 1,2017 into MEGS - NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS groups.
   CY2018 - CCC duals demonstration and Medallion 3.0 Aged Blind Disabled are enrolled in Jan ,2018 into the same CCC+ MEGS.
   CY2019 - NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS population groups Medicaid Expansion newly eligible Medically Complex MedExp Childless Adults and MedExp Caretakers population will enroll.

   The case load changes is based on the population growth and case mix between NHE -I, Consumer Directed Waivers (EDCD), Combined Waivers(ID/DD) , TechWaiver, Community No LTSS groups.
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:

   There are hospital inpatient and other COS service unit cost increase adjustments that have been incorporated.
   These have been described as adjustments to the capitated portion of the MCO MEGs.
   In addition, the pharmacy data period and contract period trend reflect substantial increase relative to past rate setting.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   Utilization changes are anticipated from the continued expansion of school and community based mental health services that are in the carved out wrap-around services and population growth including ABD from Med 3 and CCC Duals in CCC + MEGS.

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

Appendix D7 - Summary