

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

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# Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

## Facesheet

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

The name of the waiver program is Apple Health Managed Care- Blind/Disabled.

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

Initial request for new waiver. All sections are filled.

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

Document is replaced in full, with changes highlighted

Renewal request

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

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

Section A is  replaced in full  
 carried over from previous waiver period. The State:  
 assures there are no changes in the Program Description from the previous waiver period.  
 assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is  replaced in full  
 carried over from previous waiver period. The State:  
 assures there are no changes in the Monitoring Plan from the previous waiver period.

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

**Effective Dates:** This waiver/renewal/amendment is requested for a period of 2 years; effective July 1, 2015 and ending June 30, 2017.

**State Contact:** The State contact person for this waiver is Alison Robbins and can be reached by telephone at (360) 725-1634, fax at (360) 753-7315, or email at alison.robbins@hca.wa.gov.

## **Section A: Program Description**

### **Part I: Program Overview**

#### **Tribal consultation**

*The Health Care Authority (HCA) notified all federally recognized tribes in the State of Washington of this waiver and gave them the opportunity to review and comment on the waiver proposal for the original submission. We did not receive any comments.*

*For the resubmission, we sent a notification letter (attached) with an expedited timeline for responses. We received one response, from the Suquamish Tribe. This response expressed concern about payment for behavioral health services provided by tribal health care organizations for tribal members who are managed care enrollees. Managed Care contracts staff will work with the HCA Tribal Programs Administrator to develop informational materials for tribal clinics about how to ensure payment for these services and will further work with contracted MCOs to ensure they understand their responsibility for payment to tribal entities.*

*While the State continues to make clear to tribal leaders that enrollment in Apple Health managed care is voluntary for AI/AN, the Health Care Authority's (HCA's) Tribal Affairs Administrator is also educating tribal leaders about the benefits that can be gained for their members as the result of enrollment in managed care. For example, MCO's have the ability to provide expanded specialty networks, then provide assistance to enrollees in accessing services and assistance for tribal providers to get expanded services for their members. HCA staff participated in two webinars about the different systems for getting health care services, and the benefits of each and have held two meetings between MCO staff and tribal representatives. Additionally, HCA and tribal leaders and clinicians are exploring contracting opportunities with the MCOs that will enable tribal clinics to act as Primary Care Providers (PCPs) for their members, along with access to MCO specialty networks and other resources.*

*AI/AN beneficiaries who do not self declare may be enrolled in managed care. However, these enrollees may disenroll upon notification to the State by the client or authorized representative of the enrollee's AI/AN status. The State has developed a procedure to facilitate these disenrollments with a dedicated staff person to ensure these requests are handled expeditiously. However, as described above, the State continues to stress to Tribal representatives the advantages to high risk, high needs AI/AN members to enroll in an MCO that can provide an array of care management and specialty services.*

*AI/AN beneficiaries who do not wish to enroll in MCO managed care may choose to receive services from a tribal PCCM clinic if one is available to them, through the Seattle Indian Health Board in Seattle, or the Native Project in Spokane, or may receive services through the fee-for-service system.*

## **Program History and Current Activities**

*The State of Washington has operated the Apple Health (Formerly Healthy Options) managed care program for Categorically Needy TANF and TANF related Medicaid enrollees since 1993. The program currently provides a full-scope medical and limited mental health benefit for 1.3 million enrollees statewide through six Managed Care Organizations (MCOs). In 2010 and 2011, the State Medicaid agency, the Health Care Authority (HCA), conducted a competitive procurement for both the Medicaid and the Basic Health Plan (BH) (the State's program for low-income individuals not eligible for Medicaid, which terminated with the implementation of the Affordable Care Act on January 1, 2014). This procurement added the Categorically Needy blind and disabled population to the State's managed care program as a mandatory population.*

*The State negotiated new contracts for 2014 and 2015 with the five MCOs that were awarded contracts in the 2010 – 2011 competitive process. The five MCOs are:*

- *Amerigroup of Washington, Inc.*
- *Community Health Plan of Washington*
- *Coordinated Care Corporation*
- *Molina Healthcare of Washington, Inc.*
- *UnitedHealthCare Community Plan*

*Additionally, in accord with the HCA's Washington Administrative Code (182-538-067-copy attached), HCA negotiated with Columbia United Providers (CUP), an MCO local to Clark County, Washington, to contract directly with HCA for the 2015 contract year. HCA staff meets regularly with CUP to ensure contract compliance and will be conducting a Technical Assistance Monitoring visit with CUP in late spring/early summer of 2015.*

*The HCA continues to monitor contract compliance through the annual on-site monitoring visit and daily management of contract activities. HCA maintains work groups to address:*

- *Network adequacy;*
- *Program Integrity;*
- *Member materials and outreach programs;*
- *Screening, assessment and other quality activities;*
- *Deliverables required by the contract; and*
- *Contract amendments and contract development.*

*HCA's Network Administrator developed the following information on the network verification process. This process was originally developed for the 2012 contract and continues to be used today, although we continue to refine both the review process and*

*the tools that are used for the review. Service area maps and information are attached to this document.*

*Network Verification: The network verification process is not generally used in an ongoing program unless an MCO requests expansion of its service area into a service area previously unserved by that MCO. HCA's Network Administrator verifies the MCOs network submission for the proposed service area prior to assigning or enrolling eligible clients with the MCO. This network validation process differs from network monitoring as described below. Monitoring and verification use some similar processes, but differ in very clear and important ways.*

- Network verification is the process we employ to establish MCOs are developing a foundation provider network to be in place at the time of contract implementation or service area expansion. Verification is primarily a data and numbers based process supported by research to discern need, demographics, and appropriate geographic and provider type dispersal.*
- Network monitoring processes are active requirements that both HCA and the MCOs engage in while managing an active network of providers currently seeing Medicaid clients.*

*Monitoring focuses on having networks in place after a given period. Monitoring uses Access to Care standards to confirm the efficacy of the network that was verified before contract implementation or service area expansion.*

*The State continues to monitor provider networks for each of the MCOs. MCOs are required to submit a report detailing network updates on a quarterly basis, as well as upon request by HCA. In addition to medical providers, HCA monitors mental health providers contracted by the MCOs, comparing the list submitted to HCA with those providers who contract with the Regional Support Networks contracted through the Department of Social and Health Services, Division of Behavioral Health and Recovery. HCA has also begun the process of validating MCO contracts with Nursing Facilities and Skilled Nursing Facilities that provide rehabilitation services to MCO enrollees; however, the development of the validation process is ongoing at this time because of the nature of the contracting process between MCOs and SNFs.*

## **Stakeholder Outreach**

*The State works with a variety of stakeholder groups, including the Washington State Hospital Association, the Washington State Medical Association, the Washington State Pharmacy Association, and advocacy groups serving disabled clients. Managed care staff participate in community meetings such as King County's First Friday Forum and the Washington Coalition on Medicaid Outreach. The State keeps a broad array of associations and individuals on a listserv used to notify providers, consumers, and others*

*of changes to our programs. We take special care to notify stakeholders that serve the blind and disabled population of any changes or updates to the managed care program.*

*The effect of enrolling SSI blind and disabled beneficiaries continues to be mostly positive. As managed care has gained acceptance, stakeholders have come to understand that managed care can offer broader and more immediate access to health care than fee-for-service. State staff attended, and will continue to attend, meetings of special interest groups statewide. We also have a "library" of presentations that are used at community meetings and in webinars presented to providers, tribal representatives, and disability advocates to educate them about what managed care is and isn't. These presentations are updated as the program changes, benefits are added or new programs are implemented. State staff works to address the concerns of legal and disability advocates and have developed good working relationships with our counterparts at these agencies, as well as our sister state agencies, the Department of Social and Health Services (DSHS), and the Department of Health (DOH).*

## **A. Statutory Authority**

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

- a.  **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b.  **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c.  **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d.  **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

MCO

PIHP

PAHP

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

FFS Selective Contracting program (please describe)

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

- a.  **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.

*Apple Health Managed care is available in all counties. However, in three counties, managed care is voluntary:*

- *Klickitat County: Two of the three MCOs who offer services have been unable to negotiate provider contracts that allow them to meet contractual requirements for enrollment. The third MCO has a fully adequate network but because it is the only MCO with network adequacy, Klickitat remains voluntary for managed care enrollment.*
- *Clallam County: Only one MCO participates in Clallam County, so enrollment remains voluntary.*
- *Skamania County: There is one MCO available in Skamania County, therefore Skamania remains voluntary at this time.*

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

- c.  **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is,

beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

- d. \_\_\_ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
  
- e. \_\_\_ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

## B. Delivery Systems

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

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

b.  **PIHP**: Prepaid Inpatient Health Plan means an entity that:

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

The PIHP is paid on a risk basis.

The PIHP is paid on a non-risk basis.

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

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

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

e.  **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

the same as stipulated in the state plan

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

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

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

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

*Note: Contracts referenced in this document are updated continuations of the contracts awarded in a competitive procurement process conducted in 2011 for contracts that began July 1, 2012.*

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

**Sole source** procurement

**Other** (please describe) *The State uses its existing procurement authority from its concurrent 1932(a) State Plan authority to procure managed care services for these waiver enrollees.*

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

### 1. Assurances.

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

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

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

Two or more MCOs - *in areas in which there is not adequate coverage through MCOs, clients may choose to receive their services through the fee-for-service system. Please see the attached documents for an overview of MCO coverage per county.*

Two or more primary care providers within one PCCM system;

A PCCM or one or more MCOs;

Two or more PIHPs;

Two or more PAHPs;

Other: (please describe).

### 3. Rural Exception.

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

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

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

**D. Geographic Areas Served by the Waiver**

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

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

**Less than Statewide**

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)

*Please see attached plans by county map for current MCO distribution.*

## E. Populations Included in Waiver

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

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

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

\_\_\_ Mandatory enrollment  
\_\_\_ Voluntary enrollment

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

\_\_\_ Mandatory enrollment  
\_\_\_ Voluntary enrollment

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

X Mandatory enrollment  
\_\_\_ Voluntary enrollment

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

X 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

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

- Mandatory enrollment
- Voluntary enrollment

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

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

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

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

*NOTE: The State considers other health insurance to mean other health insurance that offers comparable coverage. The state provides MCOs with data regarding third party health insurance coverage for Apple Health managed care enrollees. The MCOs also track information about third party coverage for Apple Health managed care enrollees. When the MCO discovers an enrollee has third*

*party coverage comparable to Apple Health managed care, the MCO notifies the state so the enrollee may be disenrolled from the MCO.*

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

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

*Beneficiaries enrolled in the State's Program for All-Inclusive Care for the Elderly (PACE) are not enrolled in this program.*

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

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

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

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

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

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

**Other** (Please define):

- *Individuals who are:*
  - *Medically Needy beneficiaries;*
  - *In the Medicare savings program – Qualified Medicare Beneficiaries (QMBs), Qualified Disabled Working Individuals(QDWI), Special Low Income Medicare Beneficiaries (SLMB) and Qualified Individual 1(QI 1);*
  - *In the Alien Emergency Medical (AEM) program;*
  - *Eligible only for Family Planning or Take Charge benefits/services; or*
  - *Eligible only for the Breast and Cervical Cancer treatment program.*



## F. Services

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

### 1. Assurances.

- X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
  - Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
  - Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)
- \_\_\_\_\_ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- \_\_\_\_\_ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.
- X The state assures CMS that it complies with Title I of the Medicaid Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

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

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

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

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

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

The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

The State will pay for all family planning services, whether provided by network or out-of-network providers.

Other (please explain):

Family planning services are not included under the waiver.

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

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

The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating

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

*The State contracts with one MCO, Community Health Plan of Washington, that is primarily composed of FQHCs and is a choice for enrollees in all counties where there are participating FQHCs. FQHCs also contract with other MCOs in their area, which allows enrollees and potential enrollees a choice of MCOs that contract with FQHCs. The State monitors MCO coverage through the network adequacy process described in the introduction on pages six (6) and seven (7) of this document.*

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

#### 5. **EPSDT Requirements.**

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

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

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

#### 7. **Self-referrals.**

The State requires 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:

- Family Planning
- Women's Healthcare

- Immunizations

## Section A: Program Description

### Part II: Access

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

#### A. Timely Access Standards

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

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

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

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

## **B. Capacity Standards**

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

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

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

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

## C. Coordination and Continuity of Care Standards

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

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

*The State conducts yearly document review and onsite monitoring visits to all contracted MCOs; one area of particular interest is Coordination and Continuity of Care for all enrollees, but especially those with chronic health conditions.*

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

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

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

The following items are required.

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

*The State defines individuals with special health care needs as follows:*

#### ***Individual with Special Health Care Needs***

*“Individual with Special Health Care Needs” means an enrollee who meets the diagnostic and risk score criteria for Health Home Services; or is a Child with Special*

*Health Care Needs; or has a chronic or disabling condition that meets all of the following conditions:*

- *Has a biologic, psychologic, or cognitive basis;*
- *Has a chronic disease or disabling healthcare condition that is likely to continue for more than one year; and*
- *Produce one or more of the following conditions stemming from a disease;*
  - *Significant limitation in areas of physical, cognitive, or emotional functions; or*
  - *Dependency on medical or assistive devices to minimize limitations of function or activities.*

*The State has several methods of identifying clients with special health care needs:*

- *First, the State identifies clients with special health care needs via eligibility data in the State's eligibility/payment system. The State uses Recipient Aide Category (RAC) codes to identify eligibility categories; this is one method of ensuring only eligible clients are enrolled in a managed care program. MCOs receive an enrollment listing that contains client information including the RAC codes. This enables the MCO to identify which clients are in RACs that identify persons with special health care needs.*
- *Second, the State and its contracted MCOs have access to the Predictive Risk Intelligence System (PRISM) for identification and stratification of high risk enrollees and potential enrollees. PRISM is a secure web based predictive modeling and clinical decision support tool developed and implemented by the Department of Social and Health Services (DSHS). It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis using DSHS and HCA claims data and DSHS data sources. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next 12 months based on the patient's medical service events. PRISM is used in combination with the MCO's assessment process to determine the enrollee's level of need and past service utilization in order to develop a plan of care.*

*In addition to the identification of clients with chronic conditions, PRISM data can be used to identify clients living with HIV/AIDS, where they are receiving their services, and what medications the client is presently taking. PRISM data can also be used as an indicator of compliance or non-compliance with a medication and treatment regimen, and those HIV/AIDS enrollees who appear non-compliant can be contacted for follow-up and care management.*

- *Third, the State's contracted MCOs use PRISM information and the data provided by the State in enrollment files, along with their own decision*

*support tools to identify enrollees at highest risk of poor outcomes and high costs. The initial screening process used by MCO care management staff will further identify these high risk enrollees.*

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

*In the 2014 and 2015 contracts, MCOs are required to conduct an initial, brief health screen containing behavioral, developmental and physical health questions within 60 calendar days of enrollment for all new enrollees. This screening helps identify individuals with special health care needs who have not already been identified by RAC as described above.*

*Continuity of care language in the Apple Health managed care contract requires the MCO to maintain all prescriptions and allow a new enrollee to receive care from a non-participating provider for the first 90 calendar days of enrollment, or until a participating provider evaluates the enrollee's medical needs, whichever is later.*

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

1. X Developed by the MCO Care Coordinator in coordination with the enrollee's primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.

*The care plan also considers the enrollees support system, including caregivers, family, and providers of services outside the health care system. The enrollee's Primary Care Provider must participate in development of the care plan.*

2.      Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
3. X In accord with any applicable State quality assurance and utilization review standards.

- e. X **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow

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

## Section A: Program Description

### Part III: Quality

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

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office in 2003.

*NOTE: The State is currently updating the Quality Strategy. We anticipate a finalized version of the Quality Strategy to be available by the end of calendar year 2015.*

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

		Activities Conducted
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Program	Name of Organization	EQR study	Mandatory Activities	Optional Activities
MCO	<i>Qualis Health</i>		X*	X
PIHP				

**\*NOTE:** *Effective January 1, 2015, the Health Care Authority began a contract for external quality review with Qualis Health. This contract was obtained by a competitive procurement process conducted in 2014.*

*Qualis Health will conduct the same activities that the previous contractor, Aumentra Health conducted, including validation of performance measures using the HEDIS® and non-HEDIS methods (using ISCA content) for non-HEDIS measures. The State conducts annual plan monitoring activities and validation of performance improvement projects and provides the EQRO with results of the monitoring review/PIP validation for production of the annual EQR report. The State periodically conducts CAHPS surveys of subpopulations (e.g. CHIP). All plans are seeking (Amerigroup, Coordinated Care and United Healthcare, Columbia United Providers) or are accredited (Molina and Community Health Plan) by the National Committee for Quality Assurance (NCQA) and thus conduct surveys in accord with NCQA requirements.*

## Section A: Program Description

### Part IV: Program Operations

#### A. Marketing

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

##### 1. Assurances

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

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

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

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

##### 2. Details

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

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

*For 2015, the State developed two templates to provide enrollee information about Apple Health Managed Care. The first is called "Welcome to Washington Apple Health" that provides basic information about enrollment, available MCOs, changing from one MCO to another, how to request a hearing, covered benefits and whether those benefits are covered by the State or the MCO. Additionally, the State developed a template for use by each MCO, that allows the MCO to provide some specific information about how benefits are provided, such as care management, care coordination, and prenatal care and describes incentive programs allowed by the State to motivate enrollees to see their PCP for prenatal care, well-child care, and care management for chronic conditions. MCOs also provide MCO-specific contact information for customer service, grievances and appeals.*

*The State also permits MCOs to produce informational materials, including disease management and health promotional materials, social media, and radio and TV spots as approved by the State. All materials produced by MCOs and distributed to their enrollees or potential enrollees are reviewed and approved by the State prior to distribution.*

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

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

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

*State Response: The state prohibits MCOs from offering items of value to potential enrollees as an inducement to enrollment in that MCO. The state monitors this requirement on a yearly basis via the TEAMonitor process and through client and provider complaints.*

*MCOs are permitted to offer incentives to enrollees for participating in health promotion activities, such as getting adequate prenatal care and ensuring infants and children receive required well-child visits. Many MCOs offer small gift cards to stores such as Safeway, Walmart, and Fred Meyer as incentives to participate in wellness activities.*

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

*State Note: The State does not have a fixed list of languages for MCOs to translate. MCOs are required to translate for any language that is spoken by 5% or more of the population.*

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

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

## B. Information to Potential Enrollees and Enrollees

### 1. Assurances.

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

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

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

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

### 2. Details.

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

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

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

1. \_\_\_ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
2. X The languages spoken by approximately 5% percent or more of the potential enrollee/ enrollee population.
3. X Other (please explain):

*Materials that the state produces for enrollees and potential enrollees are translated into eight (8) languages; plans produce*

*materials in languages spoken by 5% or more of their enrollees. The 8 languages translated by the State are:*

- *Spanish*
- *Russian*
- *Vietnamese*
- *Korean*
- *Cambodian*
- *Laotian*
- *Somali*
- *Chinese*

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

*The State contracts for oral interpretation services separately from managed care services. Interpreter services are available for all enrollees and potential enrollees who do not speak English as their primary language, including American Sign Language for the deaf and hard of hearing. If an in-person interpreter is not available to assist the State and enrollee or potential enrollee to communicate, the State has access to the ATT Language Line, which provides a wide variety of language interpreters via telephone.*

*The State contracts with a statewide language services broker, who is required to ensure all interpreters meet state certification standards for medical interpretation.*

*MCOs must provide interpreter services to their enrollees when conducting initial screenings and assessment, and when working with enrollees and providers to develop a plan of care, as well as when the enrollee (or potential enrollee) calls the MCOs customer service center with questions about the MCO and during the grievance and appeal process.*

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

*The State sends “Welcome to Washington Apple Health” to all newly eligible potential enrollees along with their assignment letter. The assignment letter provides information about the MCO to which the potential enrollee has been assigned, along with information about how to request a change of MCO. The Handbook provides the potential enrollee with information about Apple Health managed care benefits, the contracted MCOs, and how to request an exemption or disenrollment from Apple Health managed care.*

*The state sends enrollees a yearly notice advising them that they can request a copy of the MCO-specific managed care handbook from the MCO with whom they are enrolled.*

*“Welcome to Washington Apple Health” sent through ProviderOne but if the enrollee wants another copy, it can be accessed through the State’s publications website and printed by the enrollee ([www.hca.wa.gov/Medicaid/Pages](http://www.hca.wa.gov/Medicaid/Pages)) or the enrollee can call the State’s Medicaid customer service center.*

**b. Potential Enrollee Information**

Information is distributed to potential enrollees by:

State – *Please see State’s response above and in section A.IV.A.2.a.*

Contractor (please specify) \_\_\_\_\_

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

**c. Enrollee Information**

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

(i)  the State - *Please see State’s response above and in section A.IV.A.2.a.*

(ii)  State contractor (please specify): \_\_\_\_\_

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

## C. Enrollment and Disenrollment

### 1. Assurances.

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

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

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

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

2. Details. Please describe the State's enrollment process for 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:

*In the introduction to this document we described some of our stakeholdering activities. The State regularly notifies providers and other stakeholders of changes in the Apple Health managed care program that affect them via the numbered memo process, with updates to Billing Instructions (providers receive notification of updates to Billing Instructions), and our Listserv. Categories of providers who may subscribe to the listserv can be found at <https://fortress.wa.gov/dshs/hrsalistsrvsignup/>*

*The State maintains a toll free customer service line for beneficiaries who have questions about their coverage and/or how to access services. Additionally,*

*beneficiaries and providers may contact the State via several different email boxes.*

*The State publishes notification of client updates to an extensive list of agencies and individuals via listserv and state staff attend meetings of Washington's professional agencies such as the Washington State Medical Association, the Washington State Pharmacy Association, The Washington State Hospital Association, and the Title XIX Committee. Managed care and other staff attend regularly scheduled community meetings and speak at other meetings and conferences when requested. Communication activities are ongoing and offered as needed or requested, or as changes to policy occur.*

**b. Administration of Enrollment Process.**

State staff conducts the enrollment process.

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

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: \_\_\_\_\_

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

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

**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.):

*Approximately 100,000 SSI blind and disabled clients have been enrolled in Apple Health managed care since the beginning of the original waiver period on July 1, 2012. Original enrollment of this population was carefully phased in and continues as new beneficiaries become eligible for managed care.*

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

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

i. X Potential enrollees will have at least 10 days to choose a plan.

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

*Beginning with July 1, 2014 enrollments, assignment was based on MCO performance in conducting initial screenings for new enrollees, with those MCOs who have performed better in this measure receiving more new enrollees within their capacity to serve additional enrollees.*

*Effective January 2015, assignments to each MCO will be made based on the MCO's performance under two HEDIS Clinical Performance measures (Childhood Immunization Combo 2 Status, and Comprehensive diabetes care: retinal eye exam) and one Administrative Measure (Initial Health Screen). Again, assignments are dependent on the MCOs ability to serve enrollees in a service area.*

\_\_\_\_\_ 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.

X 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 allows exemption from enrollment when the potential enrollee or enrollee meets the following criteria. The enrollee:*

- *Becomes eligible for Medicare, CHAMPUS/TRICARE or other third-party health care coverage that is comparable to Apple Health Managed Care;*
- *Is no longer eligible for managed care;*
- *Is American Indian/Alaska Native;*
- *Has a documented treatment plan for medically necessary care by a provider who is not available through any contracted MCO available in the beneficiary's service area, and enrollment would disrupt that treatment in such a way as to cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.*

*The enrollee may make the request in writing or by telephone through HCA's Medical Assistance Customer Service Center (MACSC). MACSC works with the enrollee and the enrollee's provider to obtain clinical records from the enrollee's provider if necessary to document the request. HCA program and clinical staff review the request and work with the enrollee and his/her provider(s) to initiate the disenrollment or exemption, if the enrollee meets the requirements for disenrollment or exemption.*

*If the exemption is not granted, HCA staff works with the enrollee and the enrollee's selected MCO to ensure continuity of care into managed care.*

X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 12 months or less.

**d. Disenrollment:**

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

i. X Enrollee submits request to State.

*Enrollees may transfer between Apple Health MCOs (or between MCO's, PCCM, and fee-for-service if AI/AN) prospectively on a monthly basis.*

*Ending enrollment from Apple Health managed care is subject to review and approval from the State. Ending enrollment requires that an enrollee meet one of the following conditions:*

- *The enrollee becomes eligible for Medicare, CHAMPUS/TRICARE, or any other third-party health care coverage comparable to Apple Health benefits ;*
- *The enrollee is no longer eligible for managed care;*
- *The enrollee is American Indian/Alaska Native;*
- *Has a documented treatment plan for medically necessary care by a provider who is not available through any contracted MCO available in the beneficiary's service area, and enrollment would disrupt that treatment in such a way as to cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.*

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

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

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

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

X The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

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

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

- 1) *The enrollee purposely puts the safety or property of the MCO, or the Contractors' staff, providers, patients, or visitors at risk; or*
- 2) *The enrollee engages in intentional misconduct, including refusing to provide information to the MCO about third party insurance coverage.*

*The enrollee must have received written notice from the MCO of its intent to request the enrollee's termination of enrollment, unless the state waives the requirement for notification because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.*

*HCA reviews each request for enrollee disenrollment on a case-by-case basis and provide the MCO written approval or denial of the request. The MCO must continue to provide services to the enrollee until notified by HCA that the enrollment is terminated.*

*HCA will not terminate enrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 CFR 438.56(b)(2)).*

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

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

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

## **D. Enrollee rights.**

### **1. Assurances.**

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

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

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

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

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

## **E. Grievance System**

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

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

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

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

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

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

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

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

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

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 90 days (between 20 and 90).

The State's timeframe within which an enrollee must file a **grievance** is — days *unlimited*.

**c. Special Needs**

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

*HCA's Appeals Administrator developed a working agreement with the State Office of Administrative Hearings (OAH - an independent State agency that conducts first level evidentiary hearings) to coordinate hearings related to the addition of SSI blind and disabled enrollees into Apple Health managed care and ensure timely hearings and due process for Apple Health managed care enrollees and potential enrollees.*

**F. Program Integrity**

**1. Assurances.**

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

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

The prohibited relationships are:

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

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

- X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
  - 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
  - 3) Employs or contracts directly or indirectly with an individual or entity that is
    - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

## 2. Assurances For MCO or PIHP programs

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

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality

strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

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

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

## I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

Monitoring Activity	Evaluation of Program Impact					Evaluation of Access			Evaluation of Quality			
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Review												
Oversight and monitoring of medication usage								X	X			X

\*MCOs are responsible to develop networks and submit data to the State detailing the location and number of providers; the state monitors these submissions based on location and number of providers combined with client numbers in a geographic area. As described elsewhere in this document, HCA’s Managed Care Network Administrator provides ongoing monitoring and validation of network information submitted by the contracted MCOs.



## II. Details of Monitoring Activities

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

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

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

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

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

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

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) - *The MCO is responsible for obtaining NCQA certification.*
- Detailed description of activity - *The MCO applies for NCQA certification and goes through the certification process – the MCO obtains certification, the MCO is deemed to have met certain contractual requirements that are normally audited in HCA's annual monitoring visit.*
- Frequency of use – *In accordance with NCQA guidelines, and as needed in quality and monitoring activities.*

- How it yields information about the area(s) being monitored - *NCQA reviews and produces a report of the MCO's compliance with NCQA standards. In 2015, NCQA standards will be crosswalked by State staff to CMS regulations and submitted to CMS for approval. Crosswalked and CMS approved standards shall be used in lieu of CMS requirements when monitoring contract compliance.*

c. Consumer Self-Report data

- CAHPS (please identify which one(s)) – *the State uses the Health Plan CAHPS with additional questions related to beneficiaries with disabilities.*
- State-developed survey
- Disenrollment survey
- Consumer/beneficiary focus groups

- **Personnel responsible** (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) – *MCOs are responsible for conducting an annual CAHP survey. The EQR contractor is responsible for conducting analysis including production of a report comparing MCO performance.*
- **Detailed description of activity** – *MCOs are required to follow NCQA standards for administration of the survey; we will rotate child/child with chronic conditions survey with adult survey in alternating years, beginning with the child survey in 2015.*
- **Frequency of use** – *Annually*
- **How it yields information about the area(s) being monitored** – *CAHPS measures enrollee perceptions of the quality of care and services received, including information on strengths and “opportunities for improvement”. Opportunities will be turned into action plans by both MCOs and the State to improve performance and quality of care.*

- d.  Data Analysis (non-claims)
- Denials of referral requests
  - Disenrollment requests by enrollee
    - From plan
    - From PCP within plan
  - Grievances and appeals data
  - PCP termination rates and reasons
  - Other (please describe)

- **Personnel responsible** (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) - *Contracted MCOs submit this data to the State. Data Analysts and Contracts Management Staff in the Quality and Care Management (QCM) Section of the Health Care Authority will analyze the data.*

- **Detailed description of activity** – *MCOs keep detailed records of the grievances, actions and appeals they process each quarter and submit a report detailing this information to the state. HCA separately collects grievance data in the QCM and can produce reports by MCO and type of grievance with the implementation of a new grievance/inquiry database implemented in 2014. The state standardized the collection of such data. A report of the instructions for reporting such data can be found in the index of attachments.*
- **Frequency of use** – *MCOs submit the reports quarterly.*

**How it yields information about the area(s) being monitored** - *The state intends to begin analysis specifically related to the waiver population before the end of 2015. The data will allow us to quantify and track the amount and types of grievances received and appeals processed by the MCOs, including the outcomes of the grievances and appeals. This information is used to assess common cause grievances and appeals both within single MCOs and across all MCOs. If aberrancies such as noncompliance with contract requirements are noted, corrective action or appropriate contract changes and benefit changes or clarifications can be made.*

*The analysis will assist the state with the on-site monitoring process in the selection of grievance, action and appeals files for review. HCA selects a sample of grievances during the annual monitoring review and uses a state-created and standardized checklist to assess the handling of the grievances.*

*The state will also analyze the data submission for the number and types of actions taken by the MCOs. This information allows the State to conduct utilization review tied to denial of services. Follow-up will be dependent on what the data analysis shows.*

*Additionally, the state will continue to work with the new Grievance Tracking system to analyze the number and type of complaints submitted to the state by MCOs, enrollees and providers.*

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

- Applicable programs
  - Personnel responsible
  - Detailed description of activity
  - Frequency of use
  - How it yields information about the area(s) being monitored
- e. \_\_\_\_\_ Enrollee Hotlines operated by State
- f. \_\_\_\_\_ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. X Geographic mapping of provider network

- **Personnel responsible** – *The State Medicaid Agency is responsible for this task*
- **Detailed description of activity** - *Geographic mapping is conducted in the following circumstances:*
  - *On a quarterly basis as described in section B of the waiver*
  - *When an MCO wishes to expand or contract its service area;*
  - *When the Health Care Authority deems it necessary to request a network submission from the MCOs based on credible information received from a provider or other stakeholder.*
  - *When an MCO has lost a material provider which might impact its ability to meet access standards in a service area.*

*HCA's Network Administrator evaluates submissions using GeoCoding software to ensure adequate network capacity exists in all areas for all contracted MCOs (this process is further described in Section B of the waiver).*

*Anomalies may be identified during the quarterly review of network submissions. HCA also receives notification from provider groups and other stakeholders of potential changes to an MCO's network and the Network Administrator follows up, either with all six MCOs or with one or more affected MCOs. For example, Grays Harbor Community Hospital, and its associated Specialty Clinic conducted a competitive process in 2014 to reduce the number of contracted MCOs. Submissions from all MCOs were requested as a result of this change.*

*The corrective action depends on the issue found. The Network Administrator works with network development staff at all of the MCOs to develop relationships, answer questions and provide technical assistance in submitting accurate and adequate network submissions.*

*Corrective action may include resubmitting the network to reflect contracted providers more accurately. The 2015 contract allows for sanctioning MCOs who have inaccurate networks for two quarters or more; however, this process has not yet been used because the Network Administrator has worked with MCO staff to ensure that submissions are accurate and provided in the format required by HCA.*

*The Network Administrator recently updated the GeoCoding software he uses, to be more accurate and detailed. He continues to work with MCO staff to ensure their submissions are compatible with the software upgrades.*

- **Frequency of use** - *The State receives quarterly submissions from each MCO for the MCO's statewide network.*
- **How it yields information about the area(s) being monitored** – *The analysis provides information about the location, number and type of providers by geographic location. This information is compared to the location of potential enrollees in the same geographic area to determine if the provider network is adequate to meet the needs of the population and meets the standard of 2 providers within 10 miles for urban areas and 1 within 25 miles for rural areas. Performance is analyzed and MCOs may receive enrollment or assignments based on the following thresholds:*
  - *80% or higher coverage in a service area allows an MCO to receive Medicaid eligible, self-selected enrollment and auto-assignment of clients;*
  - *60-80% Allows the MCO to receive Medicaid eligible, self-selected enrollment;*
  - *Service areas with below 60% coverage for an MCO receive no enrollment and no assignment until the MCO submits an adequate network for that service area.*
- *Exceptions to the distance standards are made in rural areas with few providers, and GeoMapping can determine these areas. In addition to using the GeoMapping function, the Network Administrator does “spot check” by calling provider offices to ensure the information submitted by the MCO is accurate and up to date. Networks are reviewed across all MCOs participating in an area to ensure that one provider office does not have the maximum panel size (approximately 1200) for each MCO or that all contracted providers are in one corner of the service area, leaving the rest of the service area underserved.*
- *Since the waiver program began in 2012, the Network Administrator has developed a process for matching Mental Health providers contracted by the MCOs to those contracted through the Regional Support Network system, so that he can track overlap of providers between systems. This also helps if Apple Health enrollees who are receiving services through the RSN system improve their mental health status and transition to receiving services through the MCO – knowing which providers contract with both systems greatly improves continuity of care for these enrollees. As mentioned above, Mental Health providers will be considered essential providers beginning in January 2015.*

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

- **Personnel responsible** – *This work was delegated to Mathematica Policy Research.*
- **Detailed description of activity** – *Mathematica will conduct the required Independent assessment – their assessment includes enrollee surveys focused on SSI enrollees, focus groups with SSI enrollees and their caretakers, interviews with stakeholders, document review, including enrollee materials.*
- **Frequency of use** – *One time per waiver cycle for the first two cycles.*
- **How it yields information about the area(s) being monitored** - *The State contracts with Mathematica Policy Research to conduct the required independent assessment of: Quality activities and their impact, access to care and cost effectiveness to monitor quality improvement activities. Mathematic will conduct an assessment again for the upcoming 2014-2016 waiver period. For the second assessment, Mathematica will review and evaluate improvement of corrections made on findings from the original assessment.*

*The State will use this information to assess program impact, access, quality, and cost-effectiveness of the addition of the SSI Blind and Disabled population into the Apple Health managed care program.*

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

- **Personnel responsible** – *MCOs submit quarterly network updates to the State Medicaid Agency*
- **Detailed description of activity** –

*The State monitors the network submission using GeoCoding to measure the adequacy of the number and type of providers in the MCOs network. MCOs submit quarterly network updates to the Health Care Authority’s Network Administrator, who has developed a high level of expertise in the use of GeoCoding and GeoMapping to track the location and number of provider contracts .*

*The quarterly report requires the MCO to indicate whether each provider is accepting new patients by line of business. This informs HCA’s analysis of access specific to the waiver population. For 2015, mental health providers were added to the essential provider list. With the exception of hospitals, the essential provider types (General/Family Practice, Pediatricians, Hospitals, mental health providers, Pharmacy and OB/gyn) the standard is two providers within ten miles in urban areas and one provider within 25 miles for rural areas.*

*Exceptions to the distance standards are made in rural areas with few providers, and GeoMapping can determine these areas. In addition to using the GeoMapping function, the Network Administrator does “spot check” by calling provider offices to ensure the information submitted by the MCO is accurate and up to date. Networks are reviewed across all MCOs participating in an area to ensure that one provider office does not have the maximum panel size (approximately 1200) for each MCO or that all contracted providers are in one corner of the service area, leaving the rest of the service area underserved.*

*As discussed in item g. above, the Network Administrator currently tracks mental health and nursing facility providers in addition to the medical providers that have traditionally been tracked in our system. This is helpful not only to ensure adequacy, but also to ensure continuity of care between systems. MCOs have the ability to contract with a wider variety of mental health providers than the RSNs; however, the foundation of the mental health networks continues to be the Community Mental Health Agencies.*

*There are currently no distance standards developed for nursing facilities; however, HCA will likely be working with the Department of Social and Health Services in the coming year to develop access standards for these facilities.*

- **Frequency of use** – *Submissions and network validation by the state is conducted quarterly.*
- **How it yields information about the area(s) being monitored** - *The State uses the information provided in the quarterly network submissions to ensure each MCO has an adequate network both geographically and by provider type, for beneficiaries enrolled with the MCO, as well as capacity for potential growth in enrollment.*

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

l.   X   On-site review

**Personnel Responsible** – *The State Medicaid Agency*

**Detailed Description of Activity** – *The State will conduct a desk review of materials and enrollee files for each of the MCOs for the waiver population. As part of the onsite visit, the state will review 10 each of the following files specific to the waiver population: Grievances, Appeals, Actions and Care Coordination for the waiver population.*

**Frequency of Use – Annual**

**How it yields information about the area(s) being monitored - Upon completion of the file review, each MCO will receive performance feedback and Technical Assistance related to the findings of the file review. MCO must submit CAP addressing deficiencies noted by the State. If the findings are severe or significant (Not Met), the CAP may be revisited during the year. The CAP is reviewed again at the following year's onsite visit, to ensure improvement in the area of deficiency.**

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

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

**Personnel Responsible - MCOs collect and track performance measure data and submit this information to the State.**

**Detailed description of Activity – MCOs track and collect this data and submit collected data to the State. The State then analyzes the data to track trends and potential improvements in outcomes. For the coming waiver period, the State will pool blind/disabled HEDIS data from the MCOs and conduct statewide analysis for a subset of the performance measures, targeted to the waiver population. This comparative analysis will be conducted annually for three years to examine performance over time.**

*The methodology for conducting this analysis is as follows:*

- *MCOs will provide de-identified data for all HEDIS measures. The MCO will identify the line of business for each enrollee, including B/D clients. HCA will pool the data across managed care plans for the B/D clients on the measures listed below.*
- *HCA will calculate rates of performance (a statewide rate) for these measures.*
- *HCA will provide this data to the MCOs.*
- *HCA will analyze the data annually to compare performance over time, producing a statewide measure of performance.*

Measures that HCA will track in the manner described above, for the waiver population, are:

- Well-child visits 3 – 6 year olds
- Adolescent well care visits
- Adult access to preventive/ambulatory health services
- Plan all cause readmission
- Ambulatory care: ED services
- Diabetes monitoring for individuals with diabetes and schizophrenia
- Cardiovascular monitoring for individuals with cardiovascular disease and schizophrenia

**Frequency of Use** – Data will be analyzed annually.

**How it yields information about the areas being monitored** – HCA will analyze the data annually for a period of 3 – 5 years to observe/assess performance over time. By analyzing the data annually over a period of years, the state will see trends emerging related to how well the MCOs are meeting the needs of SSI enrollees.

Based on MCO performance, HCA may amend the contract to require that the MCO:

- Conduct a statewide PIP to address significant areas of under-performance,
- Add contract elements that require the MCOs to outreach to these clients to ensure they are getting appropriate care or
- Incorporate performance on these measures in value-based purchasing approaches.

- o. \_\_\_\_\_ Periodic comparison of number and types of Medicaid providers before and after waiver
- p. \_\_\_\_\_ Profile utilization by provider caseload (looking for outliers)
- q. \_\_\_\_\_ Provider Self-report data  
\_\_\_\_\_ Survey of providers  
\_\_\_\_\_ Focus groups
- r. \_\_\_\_\_ Test 24 hours/7 days a week PCP availability
- t.  X  Other: (please describe) -

**To address shortcomings found in the 2014 Independent Assessment, the State has added this new monitoring item: Maintenance of updated enrollee contact information to ensure enrollees receive needed enrollee materials.**

- **Personnel Responsible** - The State Medicaid agency is responsible for coordinating this work.

- **Detailed Description of Activity -**

*The state and MCOs will work with SSI enrollees and/or their caregivers/Authorized Representatives, community based organizations and In Person Assisters to educate enrollees on the importance of keeping their contact information up to date in both the MCOs systems and by reporting it to the State through the Community Services Offices (CSOs) (SSI enrollees still maintain eligibility through the CSOs). Because materials are sent to enrollees based on the contact information provided by the enrollee or his/her Authorized Representative or parent, to some extent, the State must rely on the enrollee to maintain updated contact information; however, by working with the entities above, accuracy of the information will be improved.*

*The state and its contracted MCOs have begun collecting email addresses for new and existing enrollees – email addresses tend to remain constant even when the enrollee changes addresses, and may be a more reliable way to stay in contact with the enrollee.*

*HCA has created a new field on its HIPAA 834 transaction for email addresses. This information, as available, will be passed to the MCOs in the weekly 834 transactions provided to the agency’s contracted MCOs.*

- **Frequency of Use -** *Use of this information is ongoing.*
- **How it yields information about the area(s) being monitored -** *With updated and more accurate contact information, including email addresses the state will be able to provide enrollee materials and enrollment information in a more timely manner and with greater guarantee that the information reaches the enrollee/potential enrollee.*

u.  X  Other: (please describe):

**To address shortcomings found by the 2014 Independent Assessment, the State has added this new monitoring item: Revise enrollment notices and client handbooks to be more easily understood by the population being served.**

- **Personnel responsible -** *The State Medicaid Agency*
- **Detailed description of activity -** *Staff from the Managed Care Contracts Unit, along with staff from the Medical Assistance Customer Service Center (MACSC) and the Planning and Administration Section are working to develop a more user-friendly enrollment notice and enrollee handbooks.*
- *Using internal expertise, the enrollment notice is being updated to provide more clarity of information provided;*
- *The handbook formerly known as the "Managed Care Benefits Booklet" has been divided into two books:*

- *First, a brief handbook sent to be sent to newly eligible enrollees by the State Medicaid Agency is in development. This handbook will provide basic information about Medicaid in general, the benefits and what to expect from Managed Care. Additional information about how to change MCOs, how to request a hearing, and who to call for help is included in this handbook, as well as comparative information on MCO performance using select performance measures;*
- *Second, the State has developed a handbook template for use by the contracted MCOs in providing more specific information to their new enrollees. To ensure consistency of information, the template is provided in a format that allows the MCO to provide MCO-specific contact information and describe value added benefits and any other qualities specific to that MCO.*
- *The handbooks were broadly reviewed for clarity and completeness by external stakeholders, including the MCOs and advocacy community.*
- *The state will conduct “user testing” on newly developed materials, within the limits of available resources.*
- *The state will work with a broad network of stakeholders – both internal and external, and both public and private, to ensure adequate review of enrollee materials.*
- **Frequency of Use - Ongoing.**
- **How it yields information about the area being monitored:** *The goal of providing these updated materials is to ensure that enrollees receive materials that are helpful to them in making decisions about their health care, requesting assistance in doing so if it is needed, filing a grievance or appeal with the MCO or requesting a hearing from the state. State staff and client advocates will monitor the value of these improvements during the next waiver cycle.*

v.   X   Other: (please describe):

**To address shortcomings found by the 2014 Independent Assessment, the State has added this new monitoring item: Provide oversight and monitoring of medication use among SSI enrollees with serious mental illness to ensure appropriate medications are prescribed and covered.**

- **Personnel responsible -** *The State Medicaid Agency.*
- **Detailed Description of Activity -** *The State’s Special Assistant for the Prescription Drug Program who reports to the agency Medical Director, and staff in the pharmacy benefits program will meet regularly with MCO pharmacy managers to ensure education about covered medications is provided, and that*

*prescribers at both the Regional Support Networks and the MCOs are aware of the coverage and how to access needed medications for their patients – especially those with severe and chronic mental illness.*

*The state has also implemented a pharmacy mailbox for questions, complaints and issues to be addressed ([AppleHealthpharmacypolicy@hca.wa.gov](mailto:AppleHealthpharmacypolicy@hca.wa.gov))*

*The state provides information and technical assistance to MCOs, their Pharmacy Benefit Managers, and pharmacies statewide to ensure adequate and timely provision of mental health medications to enrollees in the waiver population.*

*The state will also conduct analysis of pharmacy complaint related data to assess trends and patterns of complaints regarding the management of the pharmacy benefit.*

- **Frequency of Use** - *The Special Assistant for the Prescription Drug Program will conduct quarterly teleconferences with MCO pharmacy managers to ensure consistency in implementation of Medicaid policy and pharmacy-related contract requirements and provide oversight of coverage of these medications to SSI enrollees. Other technical assistance is provided as needed to pharmacies, Pharmacy Benefits Managers and providers.*

*Additionally, the State will analyze encounter data provided monthly by the MCOs to monitor and track medication usage by SSI enrollees, spot trends in utilization, and conduct corrective action if outliers in the data are discovered.*

- **How it yields information about the area being monitored** - *Ongoing technical assistance will assist providers at all levels to understand the requirements of coverage for medications prescribed for the SSI population. Additionally, monitoring and tracking of encounter data will assist the state to spot areas in which there needs to be additional technical assistance to ensure appropriate coverage of medications, especially those related to mental health issues and other chronic conditions.*

w.  X  Other: (Please Describe)

**To address shortcomings found by the 2014 Independent Assessment, the State has added this new monitoring item: Explore the possibility of notifying the waiver population more than ten days prior to enrollment effective date.**

- **Personnel responsible:** *The State Medicaid Agency*
- **Detailed Description of Activity:** *Staff from the Quality and Care Management Section (QCMS) will meet with Provider One staff to discuss the timing of an earlier mailing for the waiver population (which would require an entirely different process than the one currently in place – the current process sends out*

*all assignment letters in a single run), what system changes the change would require, and the proposed cost (if any) of the change. Additionally, QCMS and Provider One staff will discuss the possibility of changing the configuration of the letter to provide more information about how Apple Health Managed Care works and what the benefits to the client are (within the limitations of the formatting available). This letter will be reviewed by internal and external stakeholders for content and readability prior to being implemented.*

- **Frequency of Use:** *Monthly as new beneficiaries become eligible for services.*
- **How it yields information about the area being monitored:** *The State Medicaid Agency would monitor enrollment statistics for the SSI blind and disabled population, including whether more potential enrollees actually selected an MCO different from the one they were assigned to, and whether subsequent enrollment changes were made.*

## Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

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

This is a renewal request.

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

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

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

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.

- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

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

*Strategy:*

*Confirmation it was conducted as described:*

*Yes*

*No. Please explain:*

*Monitoring Activities in 2012 waiver Section B. The state has described the activity and whether or not it was completed, as well as a description of the process, staff and findings.*

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

Denials of referral requests (Actions) Grievances and appeals data PCP termination rates and reasons

- **Confirm if monitoring was conducted:** *The agency did not separately analyze the SSI Blind/Disabled population. It was noted in the Independent Assessment that while grievances and appeals were resolved in a timely manner, monitoring of grievances and appeals was not completed at the population level (for specifically the SSI Blind/Disabled population). The state has collected MCO data related to grievances and appeals but has not yet analyzed the data collected. The State did not review denials of referral requests (as plans do not have prior approval requirements for referrals in network) or PCP termination rates and reasons because the data was not readily available and the state decided that review of grievance, actions and appeal data would be the focus of the review for 2012-2014.*

- **Summarize the results or findings** – N/A
- **Identify Problems** – N/A
- **Describe plan/provider-level corrective action** – N/A
- **Describe system-level program changes made** – N/A

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).

- **Confirm if monitoring was conducted** – *The State conducted a focused study on immunization rates for the Russian speaking population in Washington. The focused study provided excellent information that will allow the State to conduct activities to increase the confidence of the Russian speaking population in Washington’s health care system, and in the efficacy of immunizations. However, upon further review, we note that the results were not sufficiently connected to the waiver population to draw meaningful conclusions for the purposes of this waiver as we originally intended.*
- **Summarize the results or findings** – N/A
- **Identify Problems** – N/A
- **Describe plan/provider-level corrective action** – N/A
- **Describe system-level program changes made** – N/a

#### g. Geographic mapping of provider network

- **Confirm the Activity was conducted as described in the previous waiver preprint:** *This activity was conducted. The previous waiver described that the monitoring activity was delegated to the MCOs and that the frequency of use was annual. This activity is currently included in the quarterly monitoring process conducted by the State Medicaid Agency.*
- **Summarize the results or findings:** *The State validated and analyzed MCO network submissions on a quarterly basis. Findings are described in more detail in the attached narrative; however, as the waiver period progressed, the analysis and required submissions became more focused on the waiver population, rather than conducting analysis across all populations. The ways in which the State narrowed the focus of the analysis were:*
  - *Adding mental health providers to the list of “Essential providers”;*
  - *Adding a requirement that the MCOs show whether their contracted providers are accepting new enrollees by line of business, so that we could address issues related to lack of access for SSI enrollees;*
  - *“Spot checking” areas of concern – similar to “secret shopper” calls, the state’s Network Administrator calls providers in areas where there is a substantive change in providers (for example, the number of providers accepting SSI enrollees suddenly increases), to follow up on the MCO submission.*
  - *Providing Technical Assistance to MCO network staff to ensure their network includes sufficient number of specialty providers to serve the waiver population.*
  - *Adding a quality assurance requirement in the 2014 contract (See section 6.1.4). MCOs are required to conduct quality assurance reviews of individual providers within the Contractor’s primary care, pediatric and obstetrical network and must*

*review 25% of these network providers quarterly verifying contact information and open/closed panel status. A biannual report of the quality assurance review is due to the agency biannually.*

- *HCA will consult with the Department of Social and Health Services, Research and Analysis Administration (DSHS-RDA). RDA staff designed and guided the development of our access analysis activities. We will ask for updated methods to focus on the Blind/Disabled and other individuals with complex diagnoses, such as the expansion population. These methods will be used to assess adequacy of primary care and specialty access for these two sub-populations.*
- **Identify Problems** – *As described above, problems of incomplete or inaccurate submissions, providers included in the submission who would not accept SSI enrollees as new patients, and lack of information about mental health providers all were addressed during the waiver period. Additionally, HCA has begun tracking Nursing Facility and Skilled Nursing Facility contracts held by the MCOs.*
- **Describe plan/provider-level corrective action** – *As described in the attached narrative, the State’s Network Administrator provides ongoing Technical Assistance to MCO staff in providing up to date, technically sufficient, provider networks. The State operates on the principle that it is better to address issues early in the process rather than imposing sanctions or corrective action on the MCO. The State has threatened corrective action twice, mainly in the area of timely notification to the state of a loss of material provider. The threat, accompanied by technical assistance, was enough to avert the need for sanctions.*
- **Describe system-level program changes made** – *The State as updated its Geocoding licensure to ensure the most up-to-date tracking information is available when analyzing networks. The Network Administrator also works with the MCOs to ensure their network software is compatible with the Geocoding programs held by the State.*

**h. Independent Assessment:** *The state contracted with Mathematica Policy Research to conduct the required independent assessment of: Quality activities and their impact, Access to Care, and Cost Effectiveness to monitor quality improvement activities. Conclusions drawn as the result of this Independent Assessment are as follows, and can also be found in the “1915(b) Assessment Final Report”, attached to this document.*

### **INDEPENDENT ASSESSMENT**

#### **Monitoring Activity:**

- *Mathematica Policy Research conducted an Independent Assessment of the Healthy Options/Apple Health Blind/Disabled population experience with the first year of enrollment into managed care. This study assessed whether enrolling blind/disabled beneficiaries into managed care improved the following outcomes, compared to fee-for-service (FFS):*
  - *Access*

- *Quality*
- *Cost-effectiveness*
- *The study also assessed Washington’s program operations, including:*
  - *The process for monitoring and overseeing managed care, including:*
    - *Organization and management*
    - *Enrollment and education*
    - *Contract monitoring and performance improvement*
    - *Grievances and appeals*
  - *Outstanding issues and opportunities for improvement*

**Summary of Findings:**

1. *More than three-quarters of beneficiaries reported easy and timely access to care under Apple Health;*
2. *Utilization of health care services was slightly more favorable in the first year of Apple Health compared to the prior year;*
3. *Quality of care was mostly unchanged compared to the prior year;*
4. *Plan switching was common after the start of the program but declined over time;*
5. *Total capitation payments were smaller than projected expenditures by approximately \$60.8 million;*
6. *HCA used a number of successful practices to monitor enrollment into managed care and communicate with stakeholders, but notices and information to enrollees were sometimes unclear or not timely; and*
7. *HCA modified the program based on lessons learned, but issues related to analytic capacity, communications, and contracts continue and will be addressed over time as additional resources are made available to the managed care program.*

**Evaluation of Program Impact:**

*This area was assessed through data analysis and key informant interviews, including structured interviews with advocates, health plan staff, and state staff. Topics covered included:*

- *Organization and management*
- *Staff capacity*
- *Beneficiary education and rights*
- *Stakeholder and consumer involvement*
- *Contract monitoring and performance improvement*
- *Lessons learned*

*Regarding the specific areas of activity planned for the assessment, findings and follow-up are below:*

<b><i>Activity</i></b>	<b><i>Summary of results/ Problems identified</i></b>	<b><i>Corrective action (plan/provider level)/ Program change (system-wide level)</i></b>
<i>Enrollment</i>	<i>Enrollment into managed care</i>	<i>HCA is:</i>

<p><i>/Disenrollment</i></p>	<p><u>received mixed comments:</u>  <i>Beneficiaries were not always assigned to plans that contracted with their existing providers, and plans did not always have accurate contact information for new enrollees.</i></p> <p><u>Beneficiary education received mostly negative comments:</u>  <i>Beneficiaries were informed about managed care through advocates and written notices from HCA sent 10 days before enrollment, many of which beneficiaries did not receive or understand.</i></p>	<p><i>Working with MCOs, enrollees and advocates to provide current contact information for enrollees so that enrollment and information materials are received by the enrollee in a more timely manner.</i></p> <p><i>Modifying its enrollee handbook to make the information sent to the enrollee more understandable. As part of this process, there will be one handbook sent by the HCA and a second sent by the MCO with whom the enrollee is enrolled. The new handbooks will be available for January 2015 enrollment. (See Handbooks for detailed improvements and changes).</i></p>
<p><i>Program Integrity</i></p>	<p><u>Use of corrective actions and penalties for noncompliance received positive comments:</u>  <i>Problems with MCOs readily addressed through communication, contract amendments, and other corrective action.</i></p> <p><u>Strength of contract language and ability to monitor received mixed comments:</u>  <i>HCA makes frequent updates to MCO contracts as new requirements are needed, though additional modifications are needed (for example, network and panel size requirements for specialty providers). Significant performance and quality review conducted before enrollment and each year after, but quarterly</i></p>	<p><i>HCA now requires MCOs to submit quarterly updates of their network for analysis by the HCA. HCA has added emphasis on mental health providers (these providers are now considered “critical” along with primary care providers, hospitals, pharmacies, OB/gyn and pediatricians). Quarterly reports must include MCO data on PCPs they have gained or lost in the prior quarter and which providers are accepting new patients, by line of business.</i></p>

	<i>review of provider networks and additional “deep dives” on data anomalies would strengthen monitoring.</i>	<i>HCA will consult with DSHS-RDA to update its’ access analysis to focus on individual with complex diagnoses to ensure adequate primary care and specialty access. (See Contract Section 6.1.4) MCOs are required to conduct quarterly quality assurance of their networks; 2015 contract language further strengthens this requirement with required links to network providers (See Contract Section 6.1.7) on the MCO’s website and separate actions by the MCO to strengthened focus on mental health services throughout the contract.</i>
<i>Grievance</i>	<i><u>Resolution of client issues received mostly positive comments:</u> HCA and MCOs praised for their ability to resolve client issues that rise to their attention. <u>Ability to monitor received negative comments:</u> HCA’s ability to monitor grievances and appeals reported to the state or to the MCO was limited during the first program year.</i>	<i>HCA has implemented a standard format for submitting grievances and appeals.  HCA will implement routine analysis and reporting out of grievance trends, by type of grievance across MCOs.</i>

**Evaluation of Access:**

*This area was assessed through client surveys. The summary of findings in the surveys is below. No corrective actions or program changes have been made in response to these findings, which were generally positive.*

- *Majority of respondents had favorable ratings for:*
  - *Physician-patient communications (89.0 percent)*
  - *Helpfulness of health plan customer service staff (80.4 percent)*

- *Care coordination (88.0 percent)*
- *Majority of respondents (79.2 percent) usually or always found it easy to get needed care, tests, treatment, or appointments with specialists;*
- *Majority of respondents (84.9 percent) who needed care for an illness/injury or an appointment for routine care could usually or always obtain it as soon as needed;*
- *Beneficiaries' ratings of access and timeliness of care are similar to those of Medicaid beneficiaries enrolled in managed care nationwide.*
- *HCA will conduct another survey of Blind/Disabled enrollees in 2015 through Mathematica Research.*

### **Evaluation of Quality:**

*Mathematica reviewed quality of care and authorization in specific areas of performance that are most easily detected in the first year of a new program, for example, whether appropriate medications are prescribed for specific conditions. The topic area of provider selection was covered above in the enrollment activity. The summary of results follows. Corrective action cannot be taken at the plan or provider level as the "n" was too small to make observations at that level, however the program is addressing issues of quality in the current TeaMonitor cycle.*

- *Nine measures calculated for (1) full study population and (2) those with 12 months of enrollment in both the pre- and post-periods*
  - *Measures include appropriate medication use and coverage, LDL-C screening, HbA1c testing, eye exams, and medical attention for nephropathy*
- *For full study population:*
  - *Decrease\* in population with relevant screening and testing for cardiovascular disease, diabetes, and serious mental illness (SMI) following enrollment in managed care*
  - *Findings could result from incomplete data*
    - *Measures for 60 percent of the full study population used fewer than 12 months of data*
- *For those with 12 months of enrollment in both the pre- and post-periods:*
  - *No change in measures for asthma, diabetes, and cardiovascular disease*
  - *Decrease\* in appropriate medication use among those with SMI (20.6 percent with medication coverage during 90 percent of enrolled days versus 17.0 percent). Interestingly, medications for the treatment of SMI conditions were not carved into the managed care contract until January 2015.*

**Utilization** was also assessed by Mathematica:

- *Emergency department (ED) visits decreased\* (46.3 percent of members with at least 1 ED visit versus 43.3)*
- *Mixed story for prescription drug utilization*

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*\* Indicates a statistically significant difference at the 0.01 level*

- *Prescription drug use increased\* (3.1 average monthly fills versus 3.3)*
- *But, long-term trend shows fewer monthly fills on average*
- *Similar trends for both urban and rural residents, except:*
  - *Increased\* post-hospitalization follow-up for rural residents (22.1 percent more with follow-up within 1 week); no change for urban*
  - *Decrease in all-cause readmissions for rural residents (6.4 percent fewer with readmission within 30 days), compared to increase\* for urban (10.5 percent)*

*Finally, a **cost-effectiveness study** was conducted. The high level finding was that total capitation payments in the first year were smaller than projected expenditures by \$60.8 million.*

*Please see the complete report for more details about the Mathematica Independent Assessment.*

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

- **Confirm Activity was conducted** – *The activity was not conducted and completed as described in the previous waiver. MCOs submitted HEDIS data for Apple Health enrollees in June, 2014. However, the data is not identified by racial and ethnic group, nor is it broken out for the waiver population, so the results of the analysis will not be provided specific to the waiver population.*

*The data has been submitted to the National Committee for Quality Assurance for analysis. The results of this analysis will be available upon completion.*

- **Summarize the results or findings** – N/A
- **Identify Problems** – N/A
- **Describe plan/provider-level corrective action** – N/A
- **Describe system-level program changes made** – N/A

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

- **Confirm the activity was conducted** – *Yes the activity was conducted; however, in more detail than described.*
  1. *As described in item g. Geographic Mapping, HCA requires all MCOs to submit quarterly network submissions detailing their networks and including both the essential provider types (General/Family Practice, Pediatricians, Hospitals, Pharmacies, mental health and OB/GYN) and 15 specialty provider types. To address the needs of the waiver population, the State began regular analysis of mental health and Nursing facility providers in 2013 and will require these*

*submissions on a quarterly basis in 2015. Additionally, the State added a column in the network submission data file to address providers who accept new patients by line of business. This addition was made to address the concern that MCOs were noting providers accepting new patients, when the waiver population was being denied care by certain providers. This addition has provided a greater level of monitoring ability than the State had before.*

- 2. The State uses the information provided in the quarterly network submissions to ensure each MCO has an adequate network for all enrollees as well as capacity for potential growth in enrollment. The location of contracted providers is measured in relation to the location of MCO enrollees using GeoCoding software, that is upgraded as upgrades become available.*
  - 3. Because the quarterly review process has been ongoing for the past two years, the results are relatively predictable. The Network Administrator works on an ongoing basis with MCO network and systems staff to ensure that submissions are accurate. Additionally, providers are aware of the Network Administrator's work and often contact him if material changes to networks are about to be made. Additionally, the Network Administrator has made himself so familiar with the type and location of providers, he can often point out a discrepancy in the submission, follow up with the MCO or provider (or both) and remedy the error or omission.*
  - 4. As described in the response to item g, HCA continues to upgrade GeoCoding software as upgrades become available – this provides us with the ability to become ever more accurate in our assessment of provider network submissions.*
- Summarize the results or findings** – *The Network Administrator works on an ongoing basis with network staff at the MCOs to troubleshoot problems with submissions and ensure they are corrected. He has provided technical assistance on ensuring all data fields are correctly completed, and that appropriate updates to the providers listed (both deleting providers no longer contracted, and adding new providers in the appropriate category). Please see attached narrative provided to address both items g. and j.*
  - Identify Problems** – *As described above, problems are identified in quarterly submissions; however, the Network Administrator works with the MCOs on an ongoing basis to ensure problems are addressed as they are discovered, and that the MCOs have the guidance they need to provide the best possible network submission. We would prefer to maintain contact and address problems and questions as they arise rather than requiring formal corrective action, or imposing sanctions.*
  - Describe plan/provider-level corrective action** – *As described in the geographical analysis described in item g, HCA provides ongoing technical assistance to MCO*

*staff to ensure accurate, up-to-date submissions, which avoids the need for corrective action or sanctioning.*

- **Describe system-level program changes made** – *As described in item g, the State continues to upgrade Geocoding software as needed, and works with the plan.*

## **1. On-site review**

- **Confirm activity was conducted** – *HCA’s onsite monitoring/auditing team is called TEAMonitor. TEAMonitor is composed of staff from QCMS, DSHS, Aging and Disability Services Administration and Division of Behavioral Health and Recovery, and from the Department of Health. A relatively small group goes onsite to the MCOs; however, a large number of state staff are involved in reviewing documents provided for the pre-site-visit review.*

*The state typically performs one annual onsite visit with each of the MCOs. During the waiver period, the state performed three on-site visits. Upon review of the activities conducted at the visits, none were focused solely on the waiver population, although the visits did include records review of enrollees in the waiver population. The visits conducted included:*

- *Spring 2012 – A Contract Readiness Review for three new MCOs and two legacy MCOs to ensure readiness for implementation of a new managed care contract, resulting from a request for proposal. (NOTE: This was prior to the waiver period; however, the State is including it as a point of reference and essentially a start to the new contract which included SSI Blind/Disabled).*
- *Fall 2012 – A Technical Assistance Monitoring(TAM) visit was conducted approximately 4 months after a new managed care contract that included coverage for SSI and the Blind/Disabled population. This assessment was conducted as follow-up to the readiness review. The TAM assessed managed care contractor compliance with (three new contractors in Washington State) the State’s contract requirements, while providing technical assistance to the MCOs on the implementation of the new contract. The waiver population was discussed generally, but a targeted review of the SSI Blind/Disabled clients was not the sole focus of the visits;*
- *2013 TEAMonitor – The visit included a complete monitoring review of all areas defined in the federal monitoring protocol. File reviews (grievance, action, appeal, care coordination) was done as part of the visit, but the waiver population but was not targeted in this review.*
- *2014 TEAMonitor– The visit included a complete monitoring review of all areas defined in the federal monitoring protocol, as well as structured monitoring of the new (Section 2703 of the ACA) Health Home program, which serve high needs enrollees, but did not focus strictly on the waiver population. Again, a sample of grievance, action, appeals,*

*care coordination and additionally Health Home files were reviewed as part of the assessment.*

- **Summarize the results or findings** – *Please see attached TEAMonitor final monitoring reports for 2014.*
- **Identify Problems** – *Problems and shortcomings are identified in the final monitoring reports.*
- **Describe plan/provider-level corrective action** – *Plan level corrective action has also been provided in the attached final monitoring reports.*
- **Describe system-level program changes made** – *None made as the result of the annual monitoring site visit.*

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

- **Confirm activity was conducted** – *While we performed a Performance Improvement Project (PIP) with participation from all five MCOs who were contracted at that time. In hindsight, we note that the results were not sufficiently connected with the waiver population to draw meaningful conclusions as we originally intended. This were required to participate in a peer Medicaid MCO Performance Improvement Project intended to improve transitions between settings (Hospital to Nursing Facility, Hospital to Home, Nursing Facility to Home, one institutional Setting to another) for individuals with special health care needs or who were at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism. MCOs collaborated with providers, hospitals, Regional Support Networks, State Institutions, Long Term Care Providers and Substance Use Disorder providers to plan, execute and evaluate the project.*
- **Summarize the results or findings** – *The results of this PIP are attached to this document.*
- **Identify Problems** – *N/A*
- **Describe plan/provider-level corrective action** – *N/A*
- **Describe system-level program changes made** – *N/A*

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

- **Confirm activity was conducted** – *Performance measures were collected and are being tracked during the waiver period, however, upon further review, we note that while the*

*measures track outcomes that include the waiver population, the results of the data are not sufficiently connected with the waiver population to draw meaningful conclusions specific to this population as we originally intended. However, the performance measures collected did not show substantive problems or concerns for any population, and we extrapolate that it is reasonable to infer there were also no significant problems or concerns for the waiver population.*

- **Summarize the results or findings** – N/A
- **Identify Problems** - N/A
- **Describe plan/provider-level corrective action** – N/A
- **Describe system-level program changes made** – N/A

s.  X       **Utilization review (e.g. ER, non-authorized specialist requests) –**

- **Confirm activity was conducted** –*The state monitors MCO utilization review activities on an ongoing basis; however, when we reviewed the utilization data from the waiver period, we note that the results of the review do not separate the waiver population for the waiver period. The Independent Assessment conducted by the State’s contractor, Mathematica Policy Research conducted utilization review for this population with the following results:*

- **Summarize the results or findings** –

*Emergency department (ED) visits decreased\* (46.3 percent of members with at least 1 ED visit versus 43.3)*

*Mixed story for prescription drug utilization*

- *Prescription drug use increased\* (3.1 average monthly fills versus 3.3)*
- *But, long-term trend shows fewer monthly fills on average*

*Similar trends for both urban and rural residents, except:*

- *Increased\* post-hospitalization follow-up for rural residents (22.1 percent more with follow-up within 1 week); no change for urban*
- *Decrease in all-cause readmissions for rural residents (6.4 percent fewer with readmission within 30 days), compared to increase\* for urban (10.5 percent)*

- **Identify Problems** – *The independent assessment found areas of concern in the area of prescription drug availability and usage.*
- **Describe plan/provider-level corrective action** – *The State’s Special Assistant for Prescription Drug Program has convened a quarterly meeting of the pharmacy staff from each MCO, as well as pharmacies and Pharmacy Benefit Managers to share information,*

*provide updates on pharmacy policy and work to reduce barriers and delays for enrollees in receiving needed medications.*

- **Describe system-level program changes made** – *none are needed at this time.*

## **Section D – Cost-Effectiveness**

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

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

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

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

### **Part I: State Completion Section**

#### **A. Assurances**

- a. [Required] Through the submission of this waiver, the State assures CMS:
  - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
  - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
  - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
  - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
  - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:  
\_\_\_\_\_
- c. Telephone Number: \_\_\_\_\_
- d. E-mail: \_\_\_\_\_
- e. The State is choosing to report waiver expenditures based on  
 date of payment.  
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

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

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

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

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

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

- a.  Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  - 1.  First Year: \$\_\_\_\_\_ per member per month fee
  - 2.  Second Year: \$\_\_\_\_\_ per member per month fee
  - 3.  Third Year: \$\_\_\_\_\_ per member per month fee
  - 4.  Fourth Year: \$\_\_\_\_\_ per member per month fee
- b.  Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c.  Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.  Other reimbursement method/amount. \$\_\_\_\_\_ Please explain the State's rationale for determining this method or amount.

## E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a.  Population in the base year data
  - 1.  Base year data is from the same population as to be included in the waiver.
  - 2.  Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b.  For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- d.  [Required] Explain any other variance in eligible member months from BY to P2:
- e.  [Required] List the year(s) being used by the State as a base year: If multiple years are being used, please explain: \_\_\_\_\_
- f.  [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period Calendar Year (CY).
- g.  [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a.  [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b.  For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: R1 included a period where members were transitioning to managed care and therefore does not represent the full eligible population. During R2 a portion of the population transitioned to the Medicaid Expansion rating cohort (January 2014). We have included actual enrollment for July to December 2015 in projection year 1. Beginning in January 2014, we project 0.7% annual growth in membership based on historical growth rates and future expectations.
- d.  [Required] Explain any other variance in eligible member months from BY/R1 to P2: None

e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: SFY.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: Please reference the accompanying document entitled 20141002 Cost Effectiveness for details on any program changes.

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

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

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

For Initial Waivers:

- 2) For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.
- The State expects no change in aggregate administrative expenses associated with the population enrolled in this program.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2

Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

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

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

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

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

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

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

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

Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		<b>(PMPM in Appendix D5 Column W x projected member months should correspond)</b>

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

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

<b>1915(b)(3) Service</b>	<b>Amount Spent in Retrospective Period</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,751,500 or \$.97 PMPM R1</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1</i>
	<i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i>		<i>\$2,291,216 or 1.10 PMPM in P2</i>
<b>Total</b>	<b>(PMPM in Appendix D3 Column H x member months</b>		<b>(PMPM in Appendix D5 Column W x</b>

	<b>should correspond)</b>		<b>projected member months should correspond)</b>
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b. \_\_\_ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

Basis and Method:

1. \_\_\_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. \_\_\_ The State provides stop/loss protection (please describe):

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

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

2. \_\_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
  - i. Document the criteria for awarding the incentive payments.
  - ii. Document the method for calculating incentives/bonuses, and
  - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

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

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
  1. \_\_\_\_ [Required, if the State’s BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: \_\_\_\_  
Please document how that trend was calculated:

2. \_\_\_ [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: Trend rates were based on data from the period SFY 2005 – SFY 2013. The data for the period FY 2005 – SFY 2010 are actual realized PMPM claims. The projections for SFY 2011 – SFY 2013 were based on the prior results and a time series regression model. From this model we generated the annual trend rate from our BY (FY12) to the P1 and P2. 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.

Trend rates were based on data from the period SFY 2005 – SFY 2013. The data for the period FY 2005 – SFY 2010 are actual realized PMPM claims. The projections for SFY 2011 – SFY 2013 were based on the prior results and a time series regression model. From this model we generated the annual trend rate from our BY to the P1 and P2. Given the nature of the model these projections include in addition to the price increase, changes in technology, practice patterns, and utilization.

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.

Trends were calculated on a PMPM basis. The PMPM trends did not duplicate utilization and cost trends.

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

Others:

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

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

2. **An adjustment was necessary. The adjustment(s) is(are) listed and described below:**

i. **The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.**

For each change, please report the following:

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

B. **The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_**

C. **Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_**

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

E. **Other (please describe):**

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

iii. **Changes brought about by legal action (please describe):**

For each change, please report the following:

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

B. **The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_**

- C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
- D. \_\_\_ Other (please describe):
- iv. \_\_\_ Changes in legislation (please describe):  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- v. \_\_\_ Other (please describe):
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):

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

- 1. \_\_\_ No adjustment was necessary and no change is anticipated.
- 2. \_\_\_ An administrative adjustment was made.
  - i. \_\_\_ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. \_\_\_ Other (please describe):
  - ii. \_\_\_ FFS cost increases were accounted for.
    - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. \_\_\_ Other (please describe):

- iii. \_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
  - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase.
  - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
  - 1. \_ [Required, if the State’s BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_. Please provide documentation.
  - 2. \_\_\_ [Required, when the State’s BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State’s trend for State Plan Services.
    - i. State Plan Service trend
      - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

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

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

1. \_\_\_ We assure CMS that GME payments are excluded from base year data.
2. \_\_\_ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. \_\_\_ Other (please describe):

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

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

*Method:*

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

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

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

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States

must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

*Basis and Method:*

1. \_\_\_ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. \_\_\_ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. \_\_\_ The State has not made an adjustment because the same copayments are collected in managed care and FFS.
4. \_\_\_ Other (please describe):

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

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

*Method:*

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

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

*Basis and method:*

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

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

*Basis and Method:*

1.  Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
  2.  The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
  3.  Other (please describe):
- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
1.  We assure CMS that DSH payments are excluded from base year data.
  2.  We assure CMS that DSH payments are excluded from the base year data using an adjustment.
  3.  Other (please describe):
- l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
1.  This adjustment is not necessary as there are no voluntary populations in the waiver program.
  2.  This adjustment was made:
    - a.  Potential Selection bias was measured in the following manner:
    - b.  The base year costs were adjusted in the following manner:
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
1.  We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. \_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
4. \_\_\_ Other (please describe):

**Special Note section:**

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

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

- a. \_\_\_ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data. NOTE: This exclusion will be made in future cost projections as P1 has not yet occurred. This cost projection does not include the double payment (FFS runout and managed care capitation) that will occur in P1.
- 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.

<b>Adjustment</b>	<b>Capitated Program</b>	<b>PCCM Program</b>
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract

Adjustment	Capitated Program	PCCM Program
	Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*
1. \_\_\_ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
  2. \_ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
  3. \_\_\_ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. \_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  2. \_\_\_ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
  1.    No adjustment was made.
  2.    This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.    [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: \_\_\_\_\_ . Please document how that trend was calculated:
2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future

costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

- i.  State historical cost increases. Please indicate the years on which the rates are based: base years FY12. 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.

Trends were calculated from projections of PMPM costs by major category of service for the Washington state Categorically Needy Disabled population. PMPMs were projected, accounting for both changes in utilization and charge levels. The State uses regression and time series to develop PMPM trend rates. Therefore, all the trend components such as technology, practice patterns, and/or units of service are included into our forecasts.

Annual trends were calculated separately by category of service then applied to the base data (FY12) to project to the two renewal years of the waiver.

The annualized trends were applied by category of service to the base year data to project through the second year of the waiver. This results in an overall average PMPM trend of 1.79%.

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

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

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

- b.  **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought

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

Others:

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

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

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

i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

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

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

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

**D. \_\_\_ Determine adjustment for Medicare Part D dual eligibles.**

**E. \_\_\_ Other (please describe):**

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

- iii. \_\_\_ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. \_\_\_ Changes brought about by legal action (please describe):  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- v. \_\_\_ Changes in legislation (please describe):  
For each change, please report the following:
  - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- vi. \_\_\_  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):

Please refer to the accompanying document entitle ‘20141002 HOBD Cost Effectiveness.pdf’ for a description of all plan changes from the base year to the projection years.

- c. \_\_\_ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.
  - 1.  No adjustment was necessary and no change is anticipated.

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

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1. \_\_\_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
  - 2.  [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3)

trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

- i. State historical 1915(b)(3) trend rates
  1. Please indicate the years on which the rates are based: base years FY12 \_\_\_\_\_
  2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

Trends were calculated from projections of PMPM costs by major category of service for the Washington state Categorically Needy Disabled population. PMPMs were projected, accounting for both changes in utilization and charge levels. The State uses regression and time series to develop PMPM trend rates. Therefore, all the trend components such as technology, practice patterns, and/or units of service are included into our forecasts.

Annual trends were calculated separately by category of service then applied to the base data (FY12) to project to the next two years of the waiver (FY14 and FY15).

The annualized trends were applied by category of service to the base year data to project through the second year of the waiver. This results in an overall average PMPM trend of 1.79%.

- ii. State Plan Service Trend
  1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above 1.79% \_\_\_\_\_.

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

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

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

*Basis and Method:*

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

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

**K. Appendix D5 – Waiver Cost Projection**

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

All adjustments are explained in the accompanying document '20141002 HOBD Cost Effectiveness.pdf'.

**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.

All adjustments are explained in the accompanying document '20141002 HOBD Cost Effectiveness.pdf'.

**M. Appendix D7 - Summary**

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

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

There are several program changes including enrollment changes that affect the overall annualized rate of change. All adjustments are explained in the accompanying document '20141002 HOB D Cost Effectiveness.pdf'.

As discussed previously, R2 (specifically, January 2014) saw a decrease in the enrolled members. This was caused by members qualifying for Medicaid Expansion.

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 is no unit cost change contributing to the overall annualized rate of change beyond those included the trend.

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

There are several program changes including service changes that affect the overall annualized rate of change. All adjustments are explained in the accompanying document '20141002 HOB D Cost Effectiveness.pdf'.

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

**Part II: Appendices D.1-7**

Please see attached Excel spreadsheets.