Proposal for a Section 1915(b) Capitated Waiver Program

Waiver Renewal Submittal - Amendment

Submitted by the State of West Virginia Department of Human Services Bureau for Medical Services

August 5, 2024

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services Center for Medicaid and State Operations

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FACESHEET

The **State** of West Virginia 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 Mountain Health Trust (MHT)

Type of request. This is an:

___ Initial request for new waiver. All sections are filled.
_X_ Amendment request for existing waiver, which modifies
___ 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.
_X_ 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 24 months; effective October 1, 2023 and ending September 30, 2025.

State Contact: the State contact person for this waiver is Susan Hall and can be reached by telephone at (304) 352-4294, or e-mail at Susan.L.Hall@wv.gov.

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Please note that West Virginia does not have any federally recognized tribes located in the State.

Program History

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

This waiver renewal is for West Virginia's full-risk managed care program, Mountain Health Trust (MHT). The MHT program has successfully operated in West Virginia for thirteen waiver periods. The current waiver was approved for the period of July 1, 2021 to June 30, 2023. This waiver renewal request is for a 24-month period beginning October 1, 2023 and ending September 30, 2025.

The State continues to meet regularly with the Medical Services Fund Advisory Council, the MCOs and contractors. These meetings provide the State with a high level of oversight of program administration issues and promote continuous improvement in all aspects of the program (e.g., enrollment, health care delivery, external monitoring).

BMS also works with representatives from other State agencies as needed to raise issues of concern to their constituencies and share information about the MHT program to share with their staff and beneficiaries.

Projected for 2023 – 2025

- During the waiver period, BMS will renew and strengthen its focus on social determinants of health.
- The WVCHIP program will continue to operate under a State Plan Amendment and the MHT program; however, BMS will integrate the CHIP requirements into the Medicaid contracts with MCOs (i.e., MCOs will sign one contract for both Medicaid and WVCHIP services).

2023-2024

- BMS moved to an open cooperative procurement process. BMS implemented a Request for Application (RFA) process for managed care contracts, resulting in one MCO submitting a successful application in addition to the three incumbent

MCOs that were not subject to the application process.

2021 – 2023

- BMS integrated the Maternal Opioid Model (MOM) initiative into managed care. The model focuses on improving health outcomes for mothers and babies by addressing fragmentation of care for pregnant and postpartum women receiving Medicaid benefits.

2019 – 2021

- The WVCHIP program obtained managed care authority under a State Plan Amendment, effective January 1, 2021 and removed the program from the 1915(b) waiver authority. The WVCHIP populations remained under the MHT program and signed separate contracts with MCOs.
- As of January 2021, BMS expanded adult-dental services for the MHT population.
- Substance Use Disorder services, with the exception of Methadone, transitioned into managed care effective July 1, 2019. Services include assessment, service planning, consultation, support, crisis, behavior management, and residential treatment.
- During this waiver cycle, the State applied for and was approved for a 1915(b) waiver to create a Specialized Plan for Children and Youth, called Mountain Health Promise. A single MCO coordinates services for children in foster care.
- The State applied for and was approved for a 1915(c) Children with Serious Emotional Disorder Waiver; services include case management, independent living/skills building, job development, supported employment, in- and out-of-home respite, in-home family support and in-home family therapy.
- The State secured a waiver to the Institutes for Mental Disease exclusion rule, carving in IMD services.
- MCO re-procurement was completed during SFY 2020.
- Oversight of the outstanding claims remaining from the market exit of the MCO continued into this waiver cycle until all claims were fully and finally adjudicated.

2017 – 2019

- One MCO, of the four in West Virginia, opted to leave the market effective June 30, 2019. The State monitored enrollee transition in addition to assuring the final adjudication of all outstanding claims.
- The State made the decision to remove the point of sale pharmacy benefit from managed care to fee-for-service based on cost. The State determined that the expenditures for the pharmacy benefits to be in managed care were costing the

State significantly more money than when it was in the fee-for-service arena. This change in benefits was effective July 1, 2017.

- The State updated its network standards to further define time/distance standards and will continuously evaluate networks on an annual basis to ensure ongoing compliance and that member access does not become an issue.

- Outreach and enrollment for the MHT programs is handled by a single enrollment broker, Maximum Health Services, Inc. (Maximus). Maximus is also responsible for tracking enrollment and disenrollment in programs, plans, and providers, which is used by the State in program monitoring.

2014 – 2017

- Behavioral health services were transitioned to the managed care delivery system as of July 1, 2015. The managed care benefit includes a comprehensive range of services such as community case management, rehabilitation and skill building, recovery orientation and family education

- Two of the MCOs expanded coverage into all 55 counties, offering members a choice from four MCOs in all counties of West Virginia. As a result, the Physician Assured Access System (PAAS) program was terminated as of June 30, 2016. Members enrolled in the PAAS program were given the choice to enroll in one of the four MCOs operating in Cabell and Wayne counties.

- West Virginia expanded coverage through the Affordable Care Act, providing coverage to approximately 187,896 additional individuals and families. Expansion population under FFS transitioned into managed care on September 1, 2015. West Virginia experienced approximately a 55% increase in enrollment.

- SSI and SSI-related eligibles (excluding dual eligibles) were enrolled in managed care on January 1, 2017.

- West Virginia made changes to its current payment methods to implement the Directed Payment Program (DPP), in which provider directed payments, formerly known as Upper Payment Limit (UPL), were incorporated into the Medicaid managed care capitation rates for SFY16.

- West Virginia contracted with managed care organizations based on competitive procurement rather than through an application process. West Virginia awarded contracts to six MCOs selected for the provision of statewide managed care services for the MHT program. One of the MCOs terminated their contract and a second one decided to not participate during the SFY17 contract year. These services include administering the following benefits: physical and behavioral health services; management of the pharmacy services; and dental services.

2012-2014

- One MCO expanded statewide, allowing the State to offer a choice of at least

two MCOs or one MCO and PAAS in every county. This effectively ended the single plan rural option.

- The State received approval to cover two additional benefits in the managed care benefit package: pharmacy was implemented in April 2013, and children's dental was implemented in January 2014.

- The State discontinued Mountain Health Choices, which offered Section 1937 benchmark benefit packages authorized under the State Plan, and transitioned those eligible to MHT.

2008-2010, 2010-2012

- The MCO program expanded and beneficiaries in all 55 counties had the option to enroll in the MCO program.

2006-2008

- The State expanded the MCO program considerably, increasing capitated managed care access to 51 of the 55 counties across the State.

2002 – 2004

- In December 2003, implementation of the single plan rural option began in two counties. Also during the third waiver period, the State contracted with a third MCO to provide health care services to MHT enrollees. Contracting with this third MCO provided beneficiaries in more counties with a choice of at least two MCOs.

2000-2002

- West Virginia sought and received approval to amend the waiver and implement the single plan rural option authorized by the Balanced Budget Act of 1997 (BBA). In rural counties where only one MCO was present, Medicaid beneficiaries were enrolled in the MCO and were no longer required to choose between enrolling in the MCO or PCCM program.

1996 - 1998

- Three MCOs contracted with the State, and beneficiaries in all program counties had a choice of two or more MCOs

- Just prior to the next waiver one of the three MCOs left the program. In some counties only one MCO remained, so beneficiaries in those counties were given the choice between enrollment in the MCO or in the State's PCCM program.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for

certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

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

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

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

d. _X_ **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

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

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

Medicaid beneficiaries not enrolled in the waiver program.

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

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

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

B. Delivery Systems

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

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

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

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

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

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

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

d. _ **PCCM:** A system under which a primary care case manager contracts with the

State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

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

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

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

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

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

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

1. Assurances

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

Enrollees have a choice of four MCOs in all 55 counties in West Virginia.

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

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

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

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)):

1915(b)(4) Selective Contracting

__ Beneficiaries will be limited to a single provider in their service area (please define service area).
X 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.

X 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)
1	Barbour	MCO four plans	Aetna Better Health of West Virginia (ABHWV), Highmark Health Options West Virginia (HHOWV), The Health Plan (THP), UniCare of WV (UniCare)
2	Berkeley	MCO four plans	ABHWV, HHOWV, THP, UniCare
3	Boone	MCO four plans	ABHWV, HHOWV, THP, UniCare
4	Braxton	MCO four plans	ABHWV, HHOWV, THP, UniCare
5	Brooke	MCO four plans	ABHWV, HHOWV, THP, UniCare
6	Cabell	MCO four plans	ABHWV, HHOWV, THP, UniCare
7	Calhoun	MCO four plans	ABHWV, HHOWV, THP, UniCare
8	Clay	MCO four plans	ABHWV, HHOWV, THP, UniCare
9	Doddridge	MCO four plans	ABHWV, HHOWV, THP, UniCare
10	Fayette	MCO four plans	ABHWV, HHOWV, THP, UniCare
11	Gilmer	MCO four plans	ABHWV, HHOWV, THP, UniCare
12	Grant	MCO four plans	ABHWV, HHOWV, THP, UniCare
13	Greenbrier	MCO four plans	ABHWV, HHOWV, THP, UniCare
14	Hampshire	MCO four plans	ABHWV, HHOWV, THP, UniCare
15	Hancock	MCO four plans	ABHWV, HHOWV, THP, UniCare
16	Hardy	MCO four plans	ABHWV, HHOWV, THP, UniCare
17	Harrison	MCO four plans	ABHWV, HHOWV, THP, UniCare
18	Jackson	MCO four plans	ABHWV, HHOWV, THP, UniCare
19	Jefferson	MCO four plans	ABHWV, HHOWV, THP, UniCare
20	Kanawha	MCO four plans	ABHWV, HHOWV, THP, UniCare
21	Lewis	MCO four plans	ABHWV, HHOWV, THP, UniCare
22	Lincoln	MCO four plans	ABHWV, HHOWV, THP, UniCare
23	Logan	MCO four plans	ABHWV, HHOWV, THP, UniCare
24	Marion	MCO four plans	ABHWV, HHOWV, THP, UniCare
25	Marshall	MCO four plans	ABHWV, HHOWV, THP, UniCare
26	Mason	MCO four plans	ABHWV, HHOWV, THP, UniCare
27	McDowell	MCO four plans	ABHWV, HHOWV, THP, UniCare
28	Mercer	MCO four plans	ABHWV, HHOWV, THP, UniCare
29	Mineral	MCO four plans	ABHWV, HHOWV, THP, UniCare
30	Mingo	MCO four plans	ABHWV, HHOWV, THP, UniCare
31	Monongalia	MCO four plans	ABHWV, HHOWV, THP, UniCare

#	City / County / Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
32	Monroe	MCO four plans	ABHWV, HHOWV, THP, UniCare
33	Morgan	MCO four plans	ABHWV, HHOWV, THP, UniCare
34	Nicholas	MCO four plans	ABHWV, HHOWV, THP, UniCare
35	Ohio	MCO four plans	ABHWV, HHOWV, THP, UniCare
36	Pendleton	MCO four plans	ABHWV, HHOWV, THP, UniCare
37	Pleasants	MCO four plans	ABHWV, HHOWV, THP, UniCare
38	Pocahontas	MCO four plans	ABHWV, HHOWV, THP, UniCare
39	Preston	MCO four plans	ABHWV, HHOWV, THP, UniCare
40	Putnam	MCO four plans	ABHWV, HHOWV, THP, UniCare
41	Raleigh	MCO four plans	ABHWV, HHOWV, THP, UniCare
42	Randolph	MCO four plans	ABHWV, HHOWV, THP, UniCare
43	Ritchie	MCO four plans	ABHWV, HHOWV, THP, UniCare
44	Roane	MCO four plans	ABHWV, HHOWV, THP, UniCare
45	Summers	MCO four plans	ABHWV, HHOWV, THP, UniCare
46	Taylor	MCO four plans	ABHWV, HHOWV, THP, UniCare
47	Tucker	MCO four plans	ABHWV, HHOWV, THP, UniCare
48	Tyler	MCO four plans	ABHWV, HHOWV, THP, UniCare
49	Upshur	MCO four plans	ABHWV, HHOWV, THP, UniCare
50	Wayne	MCO four plans	ABHWV, HHOWV, THP, UniCare
51	Webster	MCO four plans	ABHWV, HHOWV, THP, UniCare
52	Wetzel	MCO four plans	ABHWV, HHOWV, THP, UniCare
53	Wirt	MCO four plans	ABHWV, HHOWV, THP, UniCare
54	Wood	MCO four plans	ABHWV, HHOWV, THP, UniCare
55	Wyoming	MCO four plans	ABHWV, HHOWV, THP, UniCare

E. Populations Included in Waiver

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

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

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

X Mandatory enrollment
___ Voluntary enrollment

Mandatory enrollment of all TANF and TANF-related children, medically frail individuals with income greater than the categorically needy threshold, but below the medically frail spenddown threshold (i.e., medically frail with $0 spenddown), *and* children with special health care needs who are enrolled in the State's Children with Special Health Care Needs program and receive services from the State, which are funded by Title V grants.

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

_X_ Mandatory enrollment
__ Voluntary enrollment

Mandatory enrollment of TANF and TANF-related adults, pregnant women and medically frail individuals with income greater than the categorically needy threshold, but below the medically needy spenddown threshold (i.e., medically frail with $0 spenddown).

_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

CMS approved mandatory enrollment of this population (excluding dual eligibles and those in residential settings and MR/DD waivers) in the previous waiver program. The State initiated enrollment of this population, as of January 1, 2017. Individuals in the aged/disabled waiver are excluded from 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

Mandatory enrollment of this population (excluding dual eligibles and those in residential settings and MR/DD waivers) became effective January 1, 2017. Individuals in the aged/disabled waiver are excluded from enrollment.

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

__ Mandatory enrollment
_X_ Voluntary enrollment

Note that enrollees of this population are excluded from managed care coverage once they obtain Medicare coverage.

__ **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

__X__ **Other** (Please define):

Adults eligible for Medicaid Expansion under the VIII Group are included within cost effectiveness expenditures.

Children from age six (6) up to age nineteen (19), above 108 percent the FPL and up to 133 percent the FPL, eligible under the Medicaid Expansion (M-CHIP) at 42 CFR 435.118. The MEGs impacted are Title XIX TANF, Title VI CSHCN, and Title XIX Traditional TANF.

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

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

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

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

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

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

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

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

__ **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.

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

X **Other** (Please define):

Medically frail individuals with incomes at or above the spenddown threshold are excluded from participation in the waiver 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 the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2),

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

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

_X_ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, as 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 one (1), and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

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

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

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

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

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

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

___ Other (please explain):

___ Family planning services are not included under the waiver.

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

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

_X_ 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 an 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:

Each MCO must contract with FQHCs such that enrollees who choose an FQHC-based provider as their PCP can do so within the PCP time and distance standards (e.g., 30 minute travel time standard). The MCO must contract with as many FQHCs as necessary to permit enrollee access to participating FQHCs without having to travel a significantly greater distance past a non-participating FQHC. An MCO with an FQHC on its panel that has no capacity to accept new patients will not satisfy these requirements. If an MCO cannot satisfy the standard for FQHC access at any time while the MCO holds a Medicaid contract, the MCO must allow its Medicaid enrollees to seek care from non-contracting FQHCs and must reimburse these providers at Medicaid fees.

___ 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.

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

6. 1915(b)(3) Services.

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

7. Self-referrals

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

- Following implementation of new benefits or populations in the managed care benefit package, members may self-refer to a provider for up to 90 days if the provider is not part of the network but is the main source of care and is given the opportunity to join the network but declines.
- MCO/PIHP/PAHP/PPCM or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.
- Each MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a primary care physician for routine services. West Virginia insurance regulations also require MCOs to allow women direct access to a women’s health specialist.

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

1.__ PCPs (please describe):

2.__ Specialists (please describe):

3.__ Ancillary providers (please describe):

4.__ Dental (please describe):

5.__ Hospitals (please describe):

6.__ Mental Health (please describe)

7.___ Pharmacies (please describe):

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

9.___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. __ Mental Health (please describe):
6. __ Substance Abuse Treatment Providers (please describe):
7. __ Urgent care (please describe):
8. __ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. __ Mental Health (please describe):
6. __ Substance Abuse Treatment Providers (please describe):
7. __ Other providers (please describe):

d. __ Other Access Standards (please describe)

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

B. Capacity Standards

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

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.206 Assurances of adequate capacity and services, in so far as these requirements are applicable.

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

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

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

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

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

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

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

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

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

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

2. Details on MCO/PIHP/PAHP enrollees with special health care needs. The following items are required.

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

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

The State has two mechanisms to identify persons with special health care needs in MCOs.

First, individuals are identified by the enrollment broker during the health assessments conducted as part of the enrollment process. Enrollment counselors, both in person or over the phone, review all health assessment forms and record

any information on medical conditions, physician preferences, or potential health problems in a comment field on the enrollment screen. This data and copies of the health assessment forms are forwarded to MCOs with the enrollment rosters sent by the State's fiscal agent.

In addition, the Office of Maternal and Child sends the Bureau for Medical Services (BMS) a list of children enrolled in the State's Children with Special Health Care Needs Program on a monthly basis. The Bureau reviews the list to identify children enrolled in an MCO and includes this information on the enrollment rosters sent by the State's fiscal agent.

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

The MCO is required to make a best effort to conduct an initial screening of each enrollee's health care needs, within forty-five (45) calendar days of the effective date of enrollment for all new enrollees. If the initial attempt to contact the enrollee is unsuccessful, the MCO must make subsequent attempts to complete the assessment. The MCO must document all contact efforts and make at least three (3) contact attempts at three (3) different times of day before considering the enrollee as unreachable.

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

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

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

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

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

c. ___Each enrollee receives **health education/promotion** information. Please explain.

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

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

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

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

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

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

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

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.

X 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.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Qlarant Quality Solutions, Inc.	Systems Performance Review	X	
		Performance Improvement Project Review	X	
		Performance Measure Validation	X	
		Annual Technical Report	X	

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
		Provider Surveys to Assess 24/7 Access		X
		Encounter Data Validation		X
		Focus Studies on Quality of Care		X

2. Assurances for PAHP program.

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

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

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

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

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

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

1. _____Provide education and informal mailings to beneficiaries and PCCMs;

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

3. _____Request PCCM's response to identified problems;
4. _____Refer to program staff for further investigation;
5. _____Send warning letters to PCCMs;
6. _____Refer to State's medical staff for investigation;
7. _____Institute corrective action plans and follow-up;
8. _____Change an enrollee's PCCM;
9. _____Institute a restriction on the types of enrollees;
10. _____Further limit the number of assignments;
11. _____Ban new assignments;
12. _____Transfer some or all assignments to different PCCMs;
13. _____Suspend or terminate PCCM agreement;
14. _____Suspend or terminate as Medicaid providers; and
15. _____Other (explain): Reduce or withhold management fees.

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

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

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

__ The complaint and appeals system.
__ Enrollee surveys.
__ Other (Please describe).

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

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

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

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.

The State allows MCOs to conduct the following marketing activities **without** State approval:

- General, non-Medicaid advertising
- Enrollee-initiated requests for phone conversations with plan staff

The State may allow MCOs to conduct the following marketing activities **with** State pre- approval:

- Mailings in response to enrollee requests
- Gifts to enrollees based on specific health events unrelated to enrollment (e.g., baby T-shirt showing immunization schedule)
- Marketing materials to potential enrollees
- Enrollee materials (Provider Directories, Member Handbooks, Member ID cards, etc.)
- Information to be used on the MCO's Website or the Internet
- Print media
- Television and radio storyboards or scripts
- Survey former or current enrollees

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.

   MCOs may provide promotional gifts of value at or under $15 per individual gift and no more than a cumulative annual value of $75 to potential MCO enrollees. The MCO may not provide gifts to providers to distribute to potential enrollees, unless such gifts are placed in the providers' office common areas and are available to all patients.

   After enrollment, the MCO may provide to enrollees pertinent items (e.g., magnet with immunization schedule) that have been pre-approved by the State prior to distribution. MCOs may only issue gift cards to enrollees in connection with their participation in MCO initiatives in the areas of health education or improved medical outcomes (e.g., reward for participation in MCO prenatal program, member surveys) unrelated to enrollment. The gift cards may not be converted to cash.

   The State will continue to monitor marketing activities during the upcoming waiver period by reviewing marketing materials prior to distribution, monitoring enrollee complaints and grievances on a quarterly basis, and monitoring disenrollment reasons on a monthly basis. The State will also provide MCOs with assistance to develop appropriate materials upon request.

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):

MCOs are required to translate marketing materials in any prevalent non-English languages identified by the State. The State considers any language spoken by five percent (5%) or more of the population to be significant. There are no prevalent non-English languages spoken by the population at the time of waiver renewal submission

On an ongoing basis, the State reviews eligibility reports, which record demographic information such as primary language at the time of the application, to determine prevalent languages. Within ninety (90) calendar days of notification from DoHS, the MCOs will make written materials available in prevalent non-English languages.

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%.

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):

MCOs are required to translate written materials in any prevalent non-English languages identified by the State. The State considers any language spoken by five percent (5%) or more of the population to be significant. No prevalent non-English languages are spoken by the population.

Additionally, the State's enrollment broker offers translation services in its call center for over twenty-five (25) languages.

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

1. __ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant."

2. X The languages spoken by approximately 5 percent or more of the potential enrollee/ enrollee population.
3. Other (please explain):

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

The enrollment broker, which performs MCO enrollment, and participating MCOs contract for translation services (Language Line) to provide real-time translation in a three-way call so that persons who do not speak English can ask questions and complete the enrollment process over the phone.
MCOs are required to provide oral interpretive services for languages on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. Oral interpretative services must be provided free of charge to enrollees and potential enrollees and must be available for all non-English languages. The MCOs must also provide audiotapes for the illiterate upon request.

The MCO must notify enrollees and potential enrollees of the availability of oral interpretation services for any language and written materials in prevalent non-English languages. The MCO must also notify enrollees and potential enrollees of how to access such services.

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

The State maintains a website with extensive programmatic information, including various publications for enrollees and potential enrollees (e.g., "Medicaid 101" materials and brochures): https://dhhr.wv.gov/bms/BMSPUB/Pages/default.aspx.

Specifically, a Guide to Medicaid is available to all enrollees and potential enrollees at the local DoHS offices and can be accessed at the following hyperlink:

https://dhhr.wv.gov/bms/BMSPUB/Documents/Guide%20to%20Medicaid%202022.pdf.

The State has an outreach process to ensure that information is available. To facilitate understanding of managed care, the enrollment broker subscribes to a language translation service.

Each MCO must maintain an Enrollee Services Department to assist enrollees in obtaining Medicaid covered services. The Enrollee Services Department, at the minimum, must be accessible during regular business hours, for at least eight (8) hours a day and through a toll-free phone number. The Enrollee Services Department must work with both Medicaid enrollees and providers to handle questions and complaints and to facilitate the provision of services.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

X State

The DoHS office provides all enrollees or potential enrollees information about the managed care programs and options through the Guide to Medicaid that can be accessed at the following hyperlink: https://dhhr.wv.gov/bms/BMSPUB/Documents/Guide%20to%20Medicaid%202022.pdf.

X Contractor (please specify):

Maximus Health Services, Inc. (Maximus) is the State's contracted Enrollment Broker organization. The Enrollment Broker provides additional information specific to the MCO programs, including a welcome packet delivered via USPS and on its website.

__ 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:

_X_ the State

_X_ State contractor (please specify): Maximus Health Services, Inc. (MAXIMUS) is the State's contracted Enrollment Broker organization.

_X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

Each MCO must develop and maintain a website to provide general information about the Medicaid managed care programs, the provider network, customer services, and the complaints and appeals process. The MCOs must ensure that enrollees have access to the most current and accurate information concerning the MCO's network provider participation.

MCOs must issue identification cards for their Medicaid enrollees to use when obtaining MCO services. The MCOs must mail enrollee handbooks to each new enrollee's household within five (5) business days of official enrollment notification to the MCO. The MCOs must provide the enrollee handbook by email after obtaining the enrollee's agreement to receive the information by email. The MCOs must advise enrollees in paper or electronic form that the information is available on the internet and includes the applicable email address, if enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

MCOs must give affected enrollees reasonable notice of any changes regarding providers. MCOs must furnish a written notice of any change in the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers that are not accepting new patients, at least thirty (30) calendar days before the intended effective date of the change.

MCOs must update the paper provider directory at least quarterly, and the electronic provider directory must be updated no later than thirty (30) calendar days after the MCO receives updated provider information. MCOs must notify enrollees annually of their right to request and obtain a provider directory. Additionally, MCOs must deliver provider directory updates to the enrollment broker monthly via a Secure File Transfer Protocol (SFTP) process, or when necessary, via any alternative data transmittal process directed by BMS.

MCOs must provide potential enrollees a copy of the provider directory, upon request. Each MCO must publish and keep current its provider directory on the MCO's website and provide enrollees a hard copy of the provider directory, upon request within five (5) business days. MCOs shall submit their provider directories annually to BMS for review and approval by October 31st.

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

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

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

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

On a regular basis, the State notifies the enrollment broker, Maximus, of newly eligible persons and adds them to the enrollment broker's mailing list. Outreach is a key component of the enrollment process with the enrollment broker providing outreach and education to potential enrollees and attempts to contact every potential enrollee. The enrollment broker:

- Has two units to support outreach and education: the call center, which staffs the toll-free telephone line, and outreach field staff, who provide statewide outreach and education.

- Is responsible for making outreach calls to potential enrollees with valid telephone numbers, when applicable.

- Mails a welcome packet to each newly eligible enrollee. For enrollees who have not made a voluntary choice after fifteen (15) days, a reminder letter is

mailed to the enrollee, to attempt to avoid auto-assignment. For potential enrollees without valid mailing addresses and/or telephone numbers or who prefer to communicate without a telephone, the enrollment broker attempts to reach as many people as possible through outreach efforts in the community.

- Provides Outreach and Education Specialists (OES) contact local DoHS offices to provide relevant updates and trainings about MHT program changes. In-service trainings are scheduled with DoHS staff as needed. In an effort to connect with Medicaid members directly, field staff may set up an informational table in the DoHS lobby. Local DoHS office staff will also provide the member with a brochure and/or the 1-800 number for referral. DoHS offices can also contact the OES to request meetings with individuals or to advise of any issues or questions.

The enrollment broker conducts various activities such as the below to engage in communities statewide:

- Enrollment broker staff attend meetings with key stakeholders in the community, including agencies working directly with potential enrollees, to coordinate with agencies to devise direct outreach opportunities to the Medicaid population, such as immunization clinics, Head Start parents meetings, preschool screenings, Adult Education Programs, WIC clinics, Health Departments and Health Fairs among others. Agencies or organizations interested in learning more about MHT may contact an OES; the OES will attend and present at any educational sessions the OES and the organization schedule for potential enrollees.

- The OES utilize other venues such as libraries, food pantries, clothing closets, laundromats, and grocery stores to display MHT program information. Other opportunities, especially around the holidays, arise when community organizations give out food baskets, Christmas toys, and clothing vouchers. Enrollment broker staff attend these events to answer questions on how to enroll by telephone, mail, or the Internet.

- Presentations in the community on Medicaid enrollment provide an avenue to help advertise the program.

- Enrollment broker staff attend provider forums held by the State during which they distribute brochures and 1-800 cards and answer questions about community outreach and the enrollment process.

The Maximus Helpline Information Specialists are available for traditional phone enrollments and enrollment counseling Monday through Friday from 8:00 a.m. to 6:00 p.m. After hours, the caller is requested to leave a message and the call is returned on the next business day.

The enrollment broker offers a secure online enrollment for potential enrollees

interested in 24/7 self-service options through the MountainHealthTrust.com website. Enrollees can use the provider search feature on the website to locate PCPs and/or specialists to ensure continuity of care. The website also offers links to project materials, frequently asked questions, and uses positive language to promote active choice. Screen reader technology is available to assist individuals with special needs in reviewing materials on the website. The website provides information on non-standard assistance available via the call center, including non-English languages and TTY phones.

OES visit Medicaid providers on a frequent basis to provide education on the enrollment process for their patients, provides program updates, answer questions, and provide outreach materials, including program brochures with the Maximus toll-free helpline number. In Maximus' experience, provider offices are key outreach locations, as providers can direct their patients to Maximus for enrollment or MCO provider changes.

The individual MCOs provide education to community providers on their role in the MHT program. The enrollment broker provides in-service trainings for MCO staff who oversee member services to help them understand the enrollment broker's role in outreach and enrollment and to learn more about community resources.

b. Administration of Enrollment Process.

__ State staff conducts the enrollment process.

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

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

Broker name: Maximus Health Services, Inc. (Maximus)

Please list the functions that the contractor will perform:

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

The enrollment broker is responsible for the following functions:

- Conducts outreach and enrollment for the MCO program (please see our response above for a description of the outreach process and the additional information included under Enrollment and Disenrollment)
- Conducts an initial health assessment screen for all new enrollees and transmits the information to the MCOs and other appropriate parties
- Processes requests for plan or provider changes
- Receives and responds to beneficiary complaints and grievances related to the enrollment process

- Provides training to county eligibility workers about the program
- Meets with community stakeholders and provides education about the program
- Tracks and reports on enrollment and disenrollment and complaint and grievance data
- Provides general outreach to beneficiaries, providers, MCO staff, state agencies, and communities about the program's status, new initiatives, etc.

___ 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.):

___ 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.

_X_ Potential enrollees will have 30-45 **days**/month(s) to choose a plan.

_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.

On a weekly basis, the State, via its Fiscal Agent, notifies the enrollment broker, Maximus, of persons eligible for MHT through a file transfer. Maximus uses this file to produce and mail enrollment packets to the newly eligible individuals. Enrollment packets contain a personalized welcome letter, a summary brochure of the MHT program, a preprinted enrollment form, a health risk assessment form that requests information about the enrollees' health status, an MCO Plan Comparison chart, and a pre-stamped envelope for the enrollee to return the enrollment form to the enrollment broker.

The materials provide information for the enrollees about how to enroll via mail, phone, or website. All materials sent by the enrollment broker to enrollees or potential enrollees throughout the process are written at a sixth (6^{th}) grade reading level.

The timing for enrollee's to voluntarily select or be auto-assigned to an MCO is as

follows:

- Approximately fourteen (14) days after the welcome packet is sent to a potential enrollee, the enrollment broker sends a reminder letter to individuals who have not yet made a voluntary plan choice.
- Approximately twenty-one (21) days after the welcome packet is sent to a potential enrollee, the enrollment broker will attempt to contact potential enrollees who have not yet made a voluntary plan choice again via phone or mail.
- Individuals who have still not made a plan selection by the thirtieth (30^{th}) day following their appearance on the weekly file will be auto assigned using the algorithm described in this waiver before the next enrollment cut-off (set by the Fiscal Agent). The enrollment broker provides the auto assignments to the Fiscal Agent via a file transfer.
- Individuals who contact the enrollment broker with a plan selection after the auto-assignment and before the cut-off date will be changed to the plan of their choosing.
- After the cut-off date, the state's Fiscal Agent reconciles the enrollment information with the updated enrollment broker data. Any assignments (voluntary choice or automatic) are scheduled to be effective the first (1st) day of the month following the cutoff date.

The auto-assignment process does not include enrollees who had previously chosen or were enrolled in an MCO within the last year and who lost and then regained eligibility. The Fiscal Agent automatically assigns the enrollee to the plan he/she was previously enrolled when determined eligible.

MCO Program

The design of the auto-assignment algorithm is based on the following logic: The auto-assignment process occurs on a county-by-county basis. Individuals are assigned in the order in which they are received, with members in the same case being assigned to the same MCO, and members with a pre-established familial relationship being assigned to the MCO with the family connection. All other cases are assigned to the lowest volume MCO during the assignment process so that an equitable number of the entire auto-assignment population is assigned to each MCO by the end of the process.

Members, including persons with special health care needs, who lose and regain eligibility for enrollment in MHT within one year, are auto-assigned to their previous MCO provider. If the person has been disenrolled for more than one year, the enrollment broker will follow the customary auto-assignment algorithm.

All MCOs are required to provide services to persons with special health care needs so there is no need to modify the auto-assignment process. Any person who is auto-assigned to an MCO can change PCPs or MCOs in their county at any time.

__ 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:

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

All West Virginia Medicaid enrollees who are children (aged 0-19 years) are granted twelve (12) months *continuous* Medicaid eligibility.

SSI enrollees are guaranteed continuous coverage of Medicaid eligibility.

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

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

Enrollees, including persons with special health care needs, who lose and regain eligibility for enrollment in MHT within one (1) year, are auto-assigned to their previous MCO. If the person has been disenrolled for more than one (1) year, the enrollment broker will follow the customary newly eligible individual process described above.

d. Disenrollment:

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

__ Enrollee submits request to State.

__ 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.

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

___ The State **does not permit disenrollment** from a single PIHP/PAHP

(authority under 1902 (a)(4) **authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.**

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of _12__ months (up to 12 months permitted).

_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:

MCO Program

MCOs may not involuntarily disenroll any enrollee except as specified below:

- Loss of eligibility for Medicaid or for participation in Medicaid managed care, including becoming a Medicare beneficiary.
- The beneficiary's permanent residence changes to a location outside the state of West Virginia.
- Continuous placement in a nursing facility, State institution or intermediate care facility for intellectual/ developmental disabilities for more than thirty (30) days.
- Error in enrollment. This may occur if the enrollee was inaccurately classified as eligible for enrollment in an MCO, if the enrollee does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for exemption is approved if the enrollment broker enrolled the enrollee while his/her exemption request was being considered.
- Upon the beneficiary's death.

The MCO may not initiate disenrollment for any enrollee except as specified above. MCOs may not terminate enrollment because of an adverse change in the enrollee's health status; the enrollee's utilization of medical services; diminished mental capacity; or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this or other enrollees). The MCO may not request disenrollment because of an enrollee's attempt to exercise his or her rights under the grievance system. The MCO must assure BMS that terminations are consistent with the reasons permitted under the contract. The State has responsibility for promptly arranging for services for any enrollee whose enrollment is terminated for reasons other than loss of Medicaid eligibility.

ii. _X_ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated

requests for enrollee transfers or disenrollments.

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

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

D. Enrollee rights

1. Assurances.

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

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

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

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

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

E. Grievance System

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

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

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

reinstated, and

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

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

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

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

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

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

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

X The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

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

b. Timeframes

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

c. Special Needs

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

The State provides assistance for persons with special needs who need help filing a request. This can be conducted orally; in addition, providers or enrollment representatives can assist the enrollee with filing the request.

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

__ The State has a grievance procedure for its PCCM and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures are operated by:

__ the State
__ the State's contractor. Please identify:
__ the PCCM
__ the PAHP.

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

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

__ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: (please specify for each type of request for review)

__ Has time frames for resolving requests for review. Specify the time period set: _ (please specify for each type of request for review)

__ Establishes and maintains an expedited review process for the following reasons: Specify the time frame set by the State for this process.

In the case where the timeframe for a standard resolution of appeals could seriously jeopardize the enrollee's life or health, or ability to attain, maintain, or regain maximum function, the timeframe is

__ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

__ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

__ Other (please explain):

F. Program Integrity

1. Assurances.

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

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

The prohibited relationships are:

1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

2. Assurances For MCO or PIHP programs

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

X State payments to an MCO or PIHP are based on data submitted by the MCO

or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

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. 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.

Part 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.

MCO and PCCM Programs

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/ disenroll	Program Integrity	Information to beneficiaries	Grievances	Timely access	PCP/ Specialist Capacity	Coordination/ continuity	Coverage/ authorization	Provider selection	Quality of care
Accreditation for Non-duplication							X	X	X	X	X	X
Accreditation for Participation												X
Consumer Self Report data	X	X	X		X		X	X	X	X	X	
Data Analysis (nonclaims)	X		X	X		X	X	X		X	X	X
Enrollee Hotlines	X	X	X		X							X
Focused Studies					X							
Geographic mapping							X	X				
Independent Assessment			X	X	X	X	X	X	X	X	X	X
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy Assurance by Plan							X	X			X	
Ombudsman	X		X		X	X					X	
On-Site Review				X	X	X	X	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	Grievances	Timely access	PCP/ Specialist Capacity	Coordination/ continuity	Coverage/ authorization	Provider selection	Quality of care
Performance Improvement Projects					X		X		X			X
Performance Measures			X			X	X	X		X		X
Periodic Comparison of # of Providers												
Profile Utilization By Provider Caseload								X				
Provider Self-Report Data												
Test 24/7 PCP Availability							X					X
Utilization Review				X			X	X	X	X		X
Other: (describe)												

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

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

Responsible Party: Qlarant

Description: MCOs are required to keep current NCQA accreditation for their Medicaid lines of business. Any new MCO contracting to provide services to enrollees of the MHT program must apply for NCQA accreditation no later than nine (9) months from its operational start date in the MHT program. MCOs submit their accreditation status reports to BMS for review and the EQRO includes information about status in the Annual Technical Report.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Accreditation strives for non-duplication of efforts and monitoring as well as monitoring quality of care.

c. X Consumer Self-Report data

X CAHPS (please identify which one(s))

____State-developed survey

X Disenrollment survey

____Consumer/beneficiary focus groups

Responsible Party: Maximus (Disenrollment Data), Qlarant (CAHPS®)

Description: Consumer Assessment of Health Plans Survey® (CAHPS®)

MCOs are required to annually conduct adult and child member satisfaction surveys using the latest version of the CAHPS®. The survey rates member's experience of care and services and includes questions regarding choices of PCPs, availability of appointments, distance to PCP offices, referrals to specialists, ability to access specialty services, and member's knowledge about how to obtain health care services.

MCOs must use CAHPS® survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Concurrent with submission of the analysis of survey results, MCOs submit an action plan to BMS. The action plan includes implementation steps, a timeline for completion, and any other elements specified by BMS. Along with the action plan, MCOs submit an evaluation describing the effectiveness of the previous year's interventions. After the first submission, MCOs submit updates on progress in implementing the action plan forty-five (45) days after the end of each quarter. The MCOs submit CAHPS® reports to BMS' EQRO, Qlarant. In turn, Qlarant reviews findings, aggregates results, and compares performance to benchmarks. Final reporting compares MCO performance to each other and MCO averages to national benchmarks. This information is included in the External Quality Review Annual Technical Report.

Disenrollments

All disenrollments are processed by the State's enrollment broker. At the time of disenrollment, the enrollment broker collects information on the reasons for the change from MCO beneficiaries and monitors this data regularly.

Frequency: Monthly (Disenrollment Data), Annually (CAHPS®)

How the Activity Yields Information on the Areas Being Monitored: The enrollment broker perspective utilizes information on disenrollments to ensure any need for program education with members or providers. The enrollment broker discusses areas of identified need with the State, and a plan is provided to the enrollment broker's Outreach and Education Specialists to ensure proper program education is provided. In addition, data is used to increase education about the program, which ultimately increases member choice enrollments.

d. X Data Analysis (non-claims)

- X Denials of referral requests
- X Disenrollment requests by enrollee
- X From plan
- ____ From PCP within plan (PCCM)
- X Grievances and appeals data
- X PCP termination rates and reasons
- X Other (please describe) – Periodic MCO reporting

Disenrollment Requests

Responsible Party: MAXIMUS

Description:

The State's enrollment broker, MAXIMUS, processes all enrollments and disenrollments. The enrollment broker produces and provides to the State's Director of Managed Care monthly reports that track all enrollment changes which are provided to the Director of Managed Care. Requests for enrollment changes are categorized by the following reasons for tracking:

- Doctor recommended
- Provider not in plan
- Enrollee moves out of the state of West Virginia
- Lack of access to providers experienced in dealing with the enrollee healthcare needs
- Lack of access to services covered under the MCO contract
- Not satisfied with auto-assigned MCO
- Not satisfied with auto-assigned Doctor
- Not satisfied with the MCO
- Not satisfied with hospital
- Provider not in Plan
- Other

The State reviews the reasons for disenrollment to identify any underlying problems with access or quality of care. If trend analysis indicates issues pertaining to quality, access, or other related topics, a specific provider corrective action is requested of

the provider.

Frequency: Monthly

How the Activity Yields Information on the Areas Being Monitored: Data analysis of enrollment and disenrollment support monitoring of program impact. Additionally, the reasons for disenrollment may highlight other access or quality issues in the program.

Grievances and Appeals

Responsible Party: Qlarant

Description:

All formal and informal grievances received by the MCOs are categorized into one of the following five areas:

- Access, attitude
- Services
- Billing / financial
- Quality of care
- Quality of practitioner office site.

MCOs report the number of denials which are categorized into the following five areas:

- Not a covered benefit / benefit exhausted
- Not medically necessary
- Provider out of network
- Systems / program issues
- Unknown

MCOs report the number of appeals which are categorized into the following four areas: medical including vision, dental, behavioral health, and pharmacy. The EQRO provides a summary of these grievances, denials, and appeals to the State on a quarterly basis.

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: Grievance, denials, and appeals data inform program integrity and quality of care. The State and MCOs monitor where participants experience issues that need to be elevated.

Denials of Referral Requests

Responsible Party: Qlarant

Description: The State and EQRO monitor MCO denials volume and frequency.

Frequency: Quarterly

How the Activity Yields Information on the Areas Being Monitored: Data analysis of denials for referral requests provides insight into timeliness of care, coverage and authorizations, and PCP and specialist capacity. MCOs report volume of denials in the following categories: not a covered benefit/benefit exhausted, not medically necessary, provider out of network, and systems/program issues.

PCP Termination Rates and Reasons

Responsible Party: MCO

Description: Each quarter, MCOs must submit a list of all PCPs with each PCP's panel size at the beginning and end of the quarter, the number of providers with open and closed panels, and the date of any PCP additions or terminations from the network.

Frequency: Quarterly. Additionally, the MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions fourteen (14) days prior to deletion. The MCOs must report any disenrollment of hospitals from the MCO's network to BMS immediately.

How the Activity Yields Information on the Areas Being Monitored: Review of provider data allows for the State to monitor for provider availability issues, timely access to care, and PCP and specialist capacity. Prior notice of network deletions help the State to work with the MCO to prepare, particularly if a large group is being deleted that may impact a large number of enrollees.

Periodic MCO Reporting

Responsible Party: MCO

Description: MCOs must provide the State with periodic reports on a variety of performance areas, including administrative, financial, utilization, quality and satisfaction, member and provider services functions, and encounter data. The State reviews these reports to monitor quality, access, and performance on an ongoing basis. Some of the specific reporting requirements for these sections are provided below.

Provider Network

In accordance with 42 CFR §438.68(b), MCOs must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. Annually,

each MCO must submit to BMS a listing all providers and facilities in the MCO's network. The MCOs submit full network documentation at least annually, which includes the name, address, specialty, identification numbers, and restrictions (e.g., not accepting new patients, age) for all primary, specialty, ancillary, and facility providers in the MCOs' networks. The MCOs must also submit a template which includes the provider-to-enrollee ratio for PCPs and OB/GYNs. **Financial Data**

Annually, on or before March 1st of each year, each MCO must submit audited financial statements for the previous year. Each MCO must also submit copies of its quarterly and annual Department of Insurance reports, as well as any revisions. Each MCO must include reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the Department of Insurance.

On a quarterly basis, each MCO must submit Medicaid-specific financial statements and information on third party liability collections. MCOs are also required to submit a summary of any claims paid outside of the encounter data and sub-capitation arrangements.

Utilization

MCOs must submit utilization information separately for TANF, WV Health Bridge (ACA Expansion) and SSI enrollees to the State quarterly in standard format, including:

- Inpatient hospitals/acute care
- Outpatient care utilization
- Other service utilization, including clinic, physician, ambulance, home health, and dental
- Vaginal and cesarean deliveries

In addition, the MCOs submit separate quarterly reports on the number of PCP visits within ninety (90) days of enrollment, number of children receiving EPSDT services, and the number of ER visits among members.

Encounter Data

MCOs submit encounter data to the State on a monthly basis, including contractor data. The MCOs are required to certify the completeness and accuracy of each set of data submitted. A contractor to the State standardizes all data for coding and adds each month's data to a historical master file that allows for program-wide analysis. The contractor develops annual encounter data summary reports addressing a variety of health service areas.

Frequency: Monthly, quarterly, annually, or at a frequency determined by the State

How the Activity Yields Information on the Areas Being Monitored: Periodic encounter data submitted by MCOs is utilized to make key decisions, establish

goals, assess and improve quality of care, monitor program integrity, validate data accuracy, and determine capitation rates.

d. X Enrollee hotlines operated by State

Responsible Party: Maximus

Description:

The State's enrollment broker operates a toll-free hotline through which members can enroll, request disenrollment or changes in MCO, file complaints, and ask questions.

Frequency: Monthly

How the Activity Yields Information on the Areas Being Monitored: Daily call monitoring is used for quality assurance purposes. In addition, data is used to increase education about the program, which ultimately increases member choice enrollments.

e. X 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).

Responsible Party: Qlarant

Description:

The EQRO conducts focus studies based on identified areas of study determined jointly with the State. Results of these studies are included in Annual Technical Reports.

Frequency: Based on study determinations with the State.

How the Activity Yields Information on the Areas Being Monitored: Conducting studies of potential issue areas allows for detailed analysis and validation of data or activities to determine extent of issue and need for corrective action.

f. X Geographic mapping of provider network

The State evaluates geographic mapping analyses of existing MCO provider networks on an annual basis to ensure that the networks have adequate geographical coverage for all points within a county. Analysis of MCO provider networks current at the time of geographic mapping demonstrate whether the networks provide geographic access within the established travel and distance standards.

Responsible Party: Myers and Stauffer LC

Description:

The State evaluates geographic mapping analyses of existing MCO provider networks on an annual basis to ensure that the networks have adequate geographical coverage for all provider locations within the county or within the county border. Analysis of MCO provider networks at the time of geographic mapping demonstrate whether the networks provide geographic access within the established travel time and distance standards.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Geographic mapping ensures that the MCO's provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers.

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

h. X Measurement of any disparities by racial or ethnic groups

Responsible Party: The State and MCOs

Description:

The State of West Virginia requires each MCO to collect meaningful enrollee-identified race, ethnicity, language, and social determinants of health (SDoH) data. The SDoH data is used to provide ongoing oversight and monitoring of the disproportionate utilization of and access to services to improve enrollee health outcomes. The measurement is effective SFY24.

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

Responsible Party: The State and MCOs

Description:

The State requires each MCO to submit documentation assuring network adequacy at the following times:

- Annually
- Prior to enrolling a new population
- Prior to implementing a new benefit
- On an ongoing basis through quarterly reporting
- Immediately at any time there has been a significant change in the existing provider network that affects access and capacity

MCOs must establish and maintain provider networks to support access to care. Networks must be comprised of hospitals, PCPs, and specialty care providers in sufficient numbers to make all covered services available in a timely manner. The MCO must contract with sufficient numbers of providers to maintain equivalent or better access to that available under Medicaid fee-for-service. Each MCO is required to submit its full provider network, including all PCPs, specialists, pharmacies, and hospitals, to the State for review, and demonstrate that any services not available in the network, even if they are not available in the fee-for-service network, will be provided out-of-network if needed.

The MCO must also ensure providers are fully credentialed and submit directory documentation to the State for review prior to any new enrollment.

The State conducts an annual review of each MCO's provider network in each county to ensure they meet appropriate access standards. BMS also reviews each MCO's provider network directory to confirm that each provider is included in the directory and that the directory clearly indicates which PCPs are not accepting new patients.

MCOs must also submit detailed network information on a quarterly basis, to ensure that networks continue to be adequate and that access standards continue to be met.

The State requires each MCO to report PCP-to-enrollee ratios and PCP panel sizes. These reports are reviewed to determine if there is sufficient capacity to serve members. Any significant network changes, such as PCP termination affecting many members, must be reported to the State immediately, along with a description of how the members in the terminated PCP’s panel will be transitioned to different PCPs. The State will then conduct plan and county specific analyses to ensure provider network standards are still being met.

Frequency: Quarterly / Annually

How the Activity Yields Information on the Areas Being Monitored: Geographic mapping providers allows the State to monitor timely access and PCP / Specialist capability and quality of care.

j._ Ombudsman

Responsible Party:

Description:

Frequency:

k. X On-site review

Responsible Party: Qlarant

Description:

The State's EQRO conducts annual on-site reviews of each MCO's administrative and operational systems to ensure that the MCO has the appropriate structure in place to meet all program requirements.

The Systems Performance Review (SPR) performance standards used to assess MCO operational systems include the BMS/MHT MCO contract requirements, standards outlined in 42 CFR §438 (Subparts A, B, C, D, E, F, and H of the Final Rule), and guidelines from other quality assurance accrediting bodies such as the National Committee for Quality Assurance (NCQA), as applicable The final standards are reviewed and approved by BMS.

The on-site systems performance review evaluates the following administrative and operational areas to ensure quality, timely, and accessible of healthcare services are provided to MHT members:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System
- Subpart H §438.608: Program Integrity Requirements Under the Contract

Review of standards are based on the following three-year schedule ensuring a comprehensive review within the CMS-mandated timeframe.

Three-Year SPR Schedule

Standard	Year 1	Year 2*	Year 3
§438.10 Information Requirements			✓
§438.56 Disenrollment Requirements and Limitations			✓
§438.100 - §438.114 Enrollee Rights and Protections			✓
§438.206 - §438.242 MCO Standards	✓		
§438.330 Quality Assessment and Performance Improvement Program		✓	
§438.402 - §438.424 Grievance and Appeal System		✓	
§438.608 Program Integrity Requirements Under the Contract	✓		

*Year 2 standards were evaluated in 2022 for Measurement Year 2021 compliance.

The EQRO conducts an interactive SPR process with the MCO in three phases: pre-site, on-site, and post-site.

- Pre-site phase: The EQRO reviews documentation submitted by the MCO such as internal policies, procedures, member handbooks, provider handbooks, newsletters, meeting minutes, access and availability monitoring reports, and other documentation that support compliance with the standards under review.

- On-site phase: The EQRO conducts the on-site review at the MCO's corporate offices and includes interviews with key MCO personnel, records reviews, and submission of additional documentation to confirm operational compliance with all performance standards. Please refer to the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

- Post-Site phase: MCOs are provided with preliminary findings and allowed an opportunity to respond with additional evidence of compliance, if available.

Frequency: Annual

How the Activity Yields Information on the Areas Being Monitored: On-site EQRO reviews provide hands on oversight for program integrity, information to beneficiaries, grievances, timely access, PCP / Specialty capacity, coordination / continuity, coverage / authorization, and quality of care. MCO systems are essential to operating the managed care program, this activity monitors program integrity, information to beneficiaries, grievances, timely access, PCP / Specialty capacity, coordination / continuity, coverage / authorization, and quality of care.

I. X Performance improvement projects [**Required** for MCO/PIHP]

X Clinical
X Non-clinical

Responsible Party: Qlarant

Description:

Each MCO must conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, sufficient and sustainable clinical care and non-clinical services that can be expected to have a favorable effect on health outcomes and enrollee satisfaction. These performance improvement projects must measure performance using objective quality indicators, implement system interventions to achieve quality improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements. Projects can be chosen from the following areas:

Clinical focus areas include:

- Primary, secondary, and/or tertiary prevention of acute conditions

- Primary, secondary, and/or tertiary prevention of chronic conditions
- Care of acute conditions
- Care of chronic conditions
- High-volume services
- High-risk services
- Continuity and coordination of care

Non-clinical focus areas include:

- Availability, accessibility, and cultural competence of services
- Interpersonal aspects of care
- Appeals, grievances, and other complaints
- Effectiveness of communications with enrollees

MCOs are required to maintain at least three (3) performance improvement projects to achieve meaningful improvement in three focus areas. The State has the option to choose the focus areas. Project proposals must be approved by BMS and the EQRO prior to project initiation. After improvement is achieved, it must be maintained for at least one year before the MCO can discontinue the project. PIP EQR activities verify the MCO used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation provides BMS and other stakeholders with a level of confidence in results.

The MCOs submit quarterly status updates and annual reports to the EQRO. MCOs complete a data and barrier analysis and identify follow-up activities for each PIP submission. MCOs use Qlarant reporting tools and worksheets to report their PIPs. Qlarant provides MCO- specific technical assistance, as requested. Qlarant conducts an annual review of each MCO's indicated performance improvement projects utilizing the CMS protocol, Validation of Performance Improvement Projects. An annual report is completed for each MCO for BMS summarizing results and providing recommendations for improvement. Please see the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Frequency: Quarterly review and Annual validation

How the Activity Yields Information on the Areas Being Monitored: While some PIPs are mandated by the State, the PIPs self-selected by the plans may vary and provide insight into areas such as the following: Information to Beneficiaries, Timely Access, Coordination / Continuity, Coverage / Authorization, and Quality of Care.

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

Responsible Party: Qlarant

Description: The EQRO evaluates performance measures to include, but are not limited to:

- 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

To ensure ongoing quality of care in the MHT program, MCOs are required to conduct and report a variety of performance measures, including from the Healthcare Effectiveness Data and Information Set® (HEDIS®), CMS Core Set of Children Health Care Quality Measures for Medicaid and CHIP, and CMS Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. The State's EQRO validates these performance measures annually, in order to evaluate the accuracy of the measures and determine the extent to which each MCO followed the specifications. Please see the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Each MCO must submit the selected performance measures required by BMS using standard measures, as defined by the current version of HEDIS® or the CMS core measure specifications. These measures must be reported to the State on an annual basis. Please see the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: The State collects a variety of performance measures through its periodic reporting and EQRO process covering several key monitoring areas including process and outcomes measures. These measures are compared to national benchmarks to gauge performance and identify gaps in care.

n. ___Periodic comparison of number and types of Medicaid providers before and after waiver

o. _____ Profile utilization by provider caseload (looking for outliers)

p. ____ Provider Self-report data

____Survey of providers

____Focus groups

q. X Test 24 hours/7 days a week PCP availability

Responsible Party: Qlarant

Description: Monitor the availability of provider hotlines and access on a 24/7 basis.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Monitoring 24/7 access allows the State to monitor timely access and quality of care.

r. X Utilization review (e.g. ER, non-authorized specialist requests)

Responsible Party: Myers and Stauffer

Description: The State collects data regarding utilization of services from MCOs.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Monitoring utilization within the MHT program provides the State insights into program integrity, timely access, coordination / continuity, coverage / authorization, and quality of care.

s. X Other: (please describe) Social Determinants of Health (SDoH) Enrollee Health Assessment

Responsible Party: Maximus

Description: Maximus conducts voluntary health assessments to both identify enrollee needs and capture enrollee SDoH health data. SDoH health assessments are voluntary, and offered to enrollees statewide during the enrollment process.

Frequency: Monthly

How the Activity Yields Information on the Areas Being Monitored: Maximus provides findings on enrollee needs to the MCOs on a monthly basis to support their care coordination for enrollees.

Section C: Monitoring Results

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

requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

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

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

_X_ This is a renewal request.

___ 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.

_X_ 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:

***Example*: Strategy:**

Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

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

Strategy: Accreditation for Participation

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

Accreditation results are included in the EQRO Annual Technical Report and posted on the BMS website. Below are results included in the 2022 Report.

MCO	NCQA Health Plan Accreditation	NCQA Health Plan Rating	Other NCQA Accreditations, Certifications, Distinctions	Next NCQA Review Date
ABHWV	Accredited	4.0 out of 5 Stars	Electronic Clinical Data	6/24/25
THP	Accredited	3.5 out of 5 Stars	None	9/17/24
UHP	Accredited	3.5 out of 5 Stars	Health Equity Accreditation, Multicultural Health Care	5/28/24

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: Consumer Self-Report Data

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

Disenrollment Survey: When a member transfers MCOs, the enrollment broker collects the reason for the member change request.

CAHPS® Survey:

MCOs conducted a survey of two distinct populations, adults and children, enrolled in each MCO in 2021. The MCOs were required to use the most current version (version 5.0) of the CAHPS® survey, a nationally recognized health care survey developed by the Agency for Healthcare Research and Quality. Each MCO incorporates the core set of questions related to health care delivery issues which includes the following: getting needed care, getting care quickly, how well doctors communicate, and health plan customer service, information, and paperwork. These questions provide respondents with the opportunity to rate their doctors, health plan, and overall health care. NQCA-certified vendors conducted the surveys on behalf of the MCOs.

Overall, for Measurement Year (MY) 2021, MCOs met or exceeded national average benchmarks for many CAHPS® survey measures relating to the effectiveness of care, access and availability of services, preventive care utilization, and member experience. The MCOs performed better than national average benchmarks in 72 percent of select CAHPS® survey measures. However, one measure that continues to present as an opportunity for improvement each year includes Advising Smokers and Tobacco Users to Quit. The West Virginia MCO average is 70 percent—below the national average.

West Virginia 2022 CAHPS® Measures (MY 2021)

Overall Survey Findings for Member Experience - Medicaid Population	MCO AVG %	
	Adult MCO	Child MCO
Getting Needed Care Composite (% Always or Usually)	85.66	93.94
Getting Care Quickly Composite (% Always or Usually)	85.68	94.90
How Well Doctors Communicate Composite (% Always or Usually)	94.71	96.96
Customer Service Composite (% Always or Usually)	97.40	95.76

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: Social Determinants of Health (SDoH) Enrollee Survey

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

Maximus currently conducts voluntary SDoH assessments statewide to identify enrollee needs during enrollment and provides findings to the MCOs on a monthly basis to support care coordination for enrollees. During the time period October 2022 – December 2023, Maximus conducted 40,369 surveys.

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

Strategy: Data Analysis (non-claims)

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: Disenrollment Requests

In the MHT program, enrollees may switch from one MCO to another at any time, for any reason. Ongoing monitoring reflects the State is in compliance with the enrollment and disenrollment requirements. Disenrollment information is taken into consideration in ongoing program monitoring and quality assurance efforts.

MCO changes have remained steady in recent years, with monitoring in 2021 and 2022 indicating that less than one (1) percent of enrollees change MCOs on a monthly basis. The monthly averages of changes are as follows:

- 2021: 0.14 percent (688) of enrollees
- 2022: 0.11 percent (646) of enrollees

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

Strategy: Grievances, Appeals and Denials

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

MCOs submit grievance, denial, and appeal "universes" to Qlarant on a quarterly basis. Qlarant collects all information and selects a random sample of records for each category. MCOs are notified of the selected sample and they provide the full records to Qlarant for review and validation activities.

Qlarant's 2022 focused study activities centered on an evaluation of member grievances, pre-service denials, and appeals received during the state fiscal year (SFY) 2022 (July 1, 2021-June 30, 2022). Qlarant examined records and evaluated MCO compliance with federal and state requirements, including 42 CFR 438.400-438.424, the Grievance and Appeal System Standard, and the following:

- §438.404 - Timely and adequate notice of adverse benefit determination
- §438.406 - Handling of grievances and appeals
- §438.408 - Resolution and notification: grievances and appeals
- §438.410 - Expedited resolution of appeals

Grievance records were evaluated to ensure the MCO provided timely acknowledgement and resolution notification. Denials, or adverse determination records, were reviewed to assess compliance with timely notification of decisions and required letter content such as communication of a member's right to file an appeal and procedures on how to do so. Appeal records were evaluated to ensure the MCO provided timely member acknowledgement and resolution notification and required letter content such as communication of a member's right to request a state fair hearing and procedures on how to make such request.

The table below includes MHT MCO grievance, denial, and appeal compliance results for SFY 2022. The MHT MCO average is also provided for each category. The MCOs performed well in meeting grievance and denial requirements; however, opportunity for improvement exists in the appeal processing and resolution procedures. None of the MCOs consistently identified the date of resolution in their notice of appeal resolution letters.

MHT MCO Grievance, Denial, and Appeal Compliance (SFY 2022)

SFY 2022 Compliance	ABHWV Compliance	THP Compliance	UHP Compliance	MHT MCO AVG Compliance
Grievances				
Grievance Compliance	100%	99%	100%	100%^
Denials				
Denials	100%	100%	100%	100%

SFY 2022 Compliance	ABHWV Compliance	THP Compliance	UHP Compliance	MHT MCO AVG Compliance
Appeals				
Appeals	92%	90%	91%	91%

^ Result is 100% due to rounding.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: PCP Termination Rates and Reasons

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

MCOs are required to provide quarterly reporting on provider termination notices. MCOs are currently not required to include the reason for termination. BMS and MCOs are currently updating the reporting requirements around this measure and providing additional instructions of what to include.

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

Strategy: Periodic MCO Reporting

X Yes
___ No. Please explain:

Summary of results:

The State reviews MCO reports to monitor quality, access, and performance on an ongoing basis. Results for each performance area designated in Section B: Monitoring Plan are as follows:

- **Provider network:** In Q4 2022, THP had the highest percentage of new enrollees auto-assigned to a PCP at 71.1%, Unicare auto-assigned 42.8% and Aetna auto-assigned 42.2%. Provider network information is also provided in other areas of this monitoring result section.

- **Financial data**: Aetna reported a 1.74 increase in total revenue from Q2 to Q3 of 2022, THP reported 1.67% and UniCare reported 1.35% increase to total revenue in the same time frame.
- **Utilization**: Quarterly utilization metrics can be found under the Utilization Review monitoring activity.
- **Encounter**: Plans continue to send monthly encounter data verification forms; Myers and Stauffer has been in receipt of these forms via FTP. These forms certify the integrity of the encounter data and provider proper recourse for all stakeholders.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: Enrollee Hotlines operated by State

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

Each month the State's enrollment broker, MAXIMUS Health Services, Inc. (MAXIMUS), sends a report reflecting enrollment broker activities to the State, including hotline activity. A summary of the number and types of hotline inquiries is provided, including new enrollments, changes, complaints, outreach and referrals. Any errors made by hotline staff are also reported monthly.

Over the last waiver period, MAXIMUS successfully processed thousands of hotline calls each month. As part of internal quality review and monitoring, hotline staff offer a customer satisfaction survey after each call. The customer satisfaction survey assesses whether the caller felt they were treated well, if the call was conducted in a timely manner, and if the caller had all their questions answered. Results of these survey calls over the last waiver period have been overwhelmingly positive, as reported by the enrollment broker.

The State reviews these reports regularly and has not identified access or quality concerns with the enrollee hotline.

No.	Member Services	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
1	Total member calls	1,795	1,793	1,673	5,261

No.	Member Services	Oct 2022	Nov 2022	Dec 2022	CY2022 Q4
2	Total calls answered	1,770	1,778	1,659	5,207
3	Member services line average answer time (seconds)	24	24	22	23
4	Member services call answer timeliness (percentage)	>98%	>>98%	>98%	>98
5	Average hold time (seconds)	3.5	3	2.5	3
6	Total abandoned calls	24	14	14	52
7	Average call abandonment rate	1.34%	0.78%	0.84%	0.99%

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

Strategy: Focused Studies

Confirmation it was conducted as described:

X Yes
__ No.

Summary of results:

Qlarant conducts a Grievance, Denials, and Appeals focused study by collecting information from each MCO; completing random sample record reviews; and evaluating MCO compliance with federal and state requirements. Please see the On-Site-Review for focused study findings.

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

Strategy: Geographic mapping of provider network

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

The State reevaluates MCO network adequacy annually. In 2021, all MCO networks were re-evaluated to ensure the access standards were being met. MCOs were required to submit geographic data maps demonstrating the availability of multiple provider types. In addition, MCOs submitted data on member-to-provider ratios for

PCPs and OB/GYNs and provided full lists of primary, specialty, ancillary, and facility providers in the network. The State reviewed the geographic maps and ratios against availability of FFS Medicaid providers to ensure its provider standards were met.

Problems identified: MCOs should submit network adequacy for all provider types, as specified in the contract, and that all facilities, counties, provider types and populations (i.e. pediatric versus adult) are accounted for in order to be deemed compliant with the exercise.

Corrective action (plan/provider level):

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

Strategy: Network adequacy assurance submitted by plan

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

Consistent with 42 CFR 438.207, BMS conducts an annual provider network adequacy analysis of MCOs serving MHT enrollees. MCOs must contract with a sufficient number of active providers that are accepting new patients within each county within the state. MCOs are considered compliant with provider network adequacy requirements, if and only if, they meet 90% of provider-to-enrollee ratios (for applicable provider types) and 90% of travel time and distance standards (for all provider types).

In 2021, all MCOs were fully compliant with requirements for the following provider types:

- PCP Network (Time and Distance)
- Basic Hospital Network
- General Dentist and Orthodontist Networks
- Behavioral Health Provider Network
- Rural Adult Inpatient (IP) Psychiatric Unit Network
- Essential Community Provider Network

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

Problems identified: Analysis of provider network adequacy revealed gaps for one or more MCOs. While MCOs filed exception requests through the State approved process and were approved by the State, BMS continues to emphasize the

importance of network adequacy for enrollee access and quality of care.

The total number of inadequacies were similar in 2020 and 2021. There were approximately 3,200 total MHT-Medicaid network inadequacies among all three MCOs, and each MCO submitted mitigation techniques for each inadequacy. In all instances, MCOs assured access to all medically necessary services for MHT enrollees.

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

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

Strategy: Ombudsman

Confirmation it was conducted as described:

___ Yes
_X_ No.

Summary of results: N/A

Strategy: On-site review

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

External Quality Review Organization Activities

The Balanced Budget Act of 1997, which became effective in 2002, specified three mandatory EQR activities:

- A systems performance review (SPR) to evaluate MCO/PIHP compliance with federal Medicaid managed care regulations.
- Validation of performance improvement projects conducted by MCO/PIHP;
- Validation of performance measures produced by MCO/PIHP; and

BMS' contracted EQRO, Qlarant, conducts these mandatory activities annually. Qlarant conducted EQR activities throughout 2022 and evaluated MCO compliance and performance for measurement years (MYs) 2021 and 2022, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities. Based on-site visits conducted in 2022, the EQRO identified the following:

- All MCOs had information systems capable of capturing and processing data required for reporting.

- All MCOs received overall performance measure validation (PMV) ratings of 100 percent, providing high confidence in MCO measure calculations and reporting.
- An analysis of PMV measures with benchmarks concludes MY 2021 MCO Medicaid averages met or exceeded national average benchmarks in 67% of measures. The following six measures demonstrated commendable performance and met or exceeded the 75th percentile benchmarks:
    - Contraceptive Care: All Women Ages 15-20 Most or Moderately Effective Method of Contraception
    - Contraceptive Care: Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 3 Days
    - Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up: Ages 18+
    - PQI 01: Diabetes Short-Term Complications Admission Rate
    - PQI 08: Congestive Heart Failure (CHF) Admission Rate
    - Sealant Receipt on Permanent First Molars - Rate 1: At Least One Sealant

Systems Performance Review (SPR)

MCOs must achieve full compliance for all standards. MCOs not achieving 100% on any standards were required to develop and implement internal corrective action plans (CAPs) to address all deficiencies identified. The most current compliance rates are for measurement year (MY) 2021. Results for the three MHT MCOs that were operational for the full measurement year are presented in the table below.

The MCOs are expected to be fully compliant with federal and contractual requirements. Compliance is assessed through an annual SPR. The review, completed onsite in March of 2022 assessed each MCO's measurement year (MY) 2021 compliance with federal and state regulations and requirements as it served the West Virginia Medicaid population.

The table below displays 2022 (MY 2021) MHT MCO SPR results by standard and identifies an overall weighted average.

2022 MHT MCO SPR Results (MY 2021 Compliance)

Standard	ABHWV	THP	UHP	MHT MCO AVG
§438.330 Quality Assessment and Performance Improvement Program	100%	100%	100%	100%
§438.402 - §438.424: Grievance and Appeal System	100%	98%	90%	96%
Overall Weighted Score	100%	98%	91%	97%

While findings indicate that overall, stakeholders can have high confidence in the MHT MCOs' level of compliance. All MCOs demonstrated 100 percent compliance in the Quality Assessment and Performance Improvement Program Standard. Not all MCO met full compliance standards related to the Grievance and Appeal System. ABHWV scored 100 percent compliance in the 2022 SPR. THP and UHP had overall scores of 98 and 91 percent, respectively. In response to these results, THP and UHP were required to develop CAPs for not meeting full compliance.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

Problems identified: THP failed to meet all elements of the 438.206 Availability of Services standard. UHP failed to meet all elements of three standards: 438.206 Availability of Services. 438.207 Assurances of Adequate Capacity and Services, 438.208 Coordination, and Continuity of Care.

Corrective action (plan/provider level): Both THP and UHP effectively developed and completed CAPs based on 2022 SPR findings. In some cases, the MCOs corrected deficiencies before the formal CAP process was initiated. For purposes of reporting, these elements/components were still counted as requiring a CAP due to not meeting requirements in the 2022 SPR. All required CAPs were for noncompliance in the Grievance and Appeal System Standard.

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

Strategy: Performance Improvement Projects

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

The State requires three (3) performance improvement projects (PIPs): two state mandated PIPs and one selected by the MCO. The State's EQRO, Qlarant, validated each MCO's chosen PIPs as part of the annual external quality review. Qlarant conducted an evaluation of the methodology and outcomes reported by

each MCO for each clinical and service PIP to ensure that PIPs were designed, conducted, and reported in a methodologically sound manner. Qlarant completed the validation using the CMS Protocol, Validating Performance Improvement Projects – A Protocol for use in Conducting Medicaid External Quality Review Activities, as a guideline in PIP review activities. Qlarant conducted an individual evaluation for each PIP and provided educational opportunities, where appropriate, to each MCO for use in improving its PIPs. The following describes the most recent PIPs for each MCO.

All MCOs are required to participate in the state-mandated Annual Dental Visits for 2-3 Year Olds PIP and the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP. Additionally, MCOs were able to choose a topic for a third required PIP. All MCOs' PIPs are summarized in the table below.

Table: PIP Topics, Description, and Goals

PIP validation results for 2022 MCO-reported PIPs, including MY 2021 activities and performance measure (PM) rates, are included in this report. Table 3 highlights key elements of the two state-mandated PIPs for the MHT program: (1) Annual Dental Visits and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.

MHT State-Mandated PIPs

State Mandated PIP: Annual Dental Visits	
Performance Measure(s), Measure Steward, and Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure steward:** NCQA **Population:** Children 2-3 years of age **PM 2:** Percentage of Eligibles that Received Preventive Dental Services **Measure steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age
Aim	Will implementation of targeted enrollee/provider/MCO interventions improve rates of annual dental visits for enrollees 2-3 years old and eligibles receiving preventive dental services for enrollees 1-20 years old each measurement year?
Phase	Medicaid: 4th Remeasurement

State Mandated PIP: Annual Dental Visits	
Findings	• The COVID-19 public health emergency continued to adversely influence enrollees seeking dental care and likely impacted MY 2021 performance for the dental PIP more than other areas of care. Dental office capacity was impacted by staffing shortages. • The MCO Medicaid weighted average improved from MY 2020 to MY 2021 in both PIP measures, but did not exceed MY 2017 baseline performance. • The MCOs received an average PIP validation score of 87 percent, indicating (overall) stakeholders can have moderate confidence the MCOs adhered to acceptable methodology for all phases of design, data collection, and analysis with results yielding improvement. Individual MCO validation results ranged from 81-100 percent.

State Mandated PIP: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	
Performance Measure(s), Measure Steward, and Population	**PM 1:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day Follow-Up (Total) **Measure steward:** NCQA **Population:** Adolescents and adults 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence
Aim	Will implementation of targeted enrollee/provider/MCO interventions improve the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Day Follow-Up) rate for enrollees 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence each measurement year?
Phase	Medicaid: 2nd Remeasurement
Findings	• All MCOs demonstrated statistically significant improvement with an increase in the weighted average from 41.91 percent (baseline) to 52.66 percent (remeasurement 2). • The MCOs improved follow-up care by 25.65 percent. • All MCOs sustained improvement with all remeasurements exceeding baseline performance. • Telehealth services improved access to care for follow-up visits. • All MCOs received a PIP validation score of 100 percent • BMS elected to close the PIP due to the successfully demonstrating statistically significant and sustained improvement.

The table below provides an overview of each MCO-selected PIP for 2022 PIPs, including MY 2021 activities.

MCO-Selected PIPs

ABHWV	
Topic	Care for Adolescents
Performance Measure(s), Measure Steward, and Population	**PM 1:** Immunizations for Adolescents - Combination 2 **Measure steward:** NCQA **Population:** Adolescents 13 years of age **PMs 2 and 3:** Child and Adolescent Well-Care Visits • 12-17 Year Olds • 18-21 Year Olds **Measure steward:** NCQA **Population:** Adolescents and adults 12-21 years of age
Findings	• ABHWV reported its first Medicaid remeasurement rates for the Care for Adolescents PIP measures: Immunizations for Adolescents (Combination 2) and Child and Adolescent Well-Care Visits (12-17 and 18-21 Year Olds). • ABHWV demonstrated statistically significant improvement in the Medicaid Adolescents Well-Care Visits 12-17 Year Olds measure. • ABHWV's validation score was 100 percent.
THP	
Topic	Promoting Health and Wellness in Children and Adolescents
Performance Measure(s), Measure Steward, and Population	**PM 1:** Child and Adolescent Well-Care Visits - Total **Measure steward:** NCQA **Population:** Children, adolescents, and adults 3-21 years of age **PMs 2 and 3:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Body Mass Index (BMI) Percentile Documentation • Counseling for Nutrition **Measure steward:** NCQA **Population:** Children and adolescents 3-17 years of age
Findings	• THP reported its first Medicaid remeasurement rates for the Child and Adolescent Well-Care Visits (Total) measure and third Medicaid remeasurement rates for its Weight Assessment and Counseling for Nutrition - BMI Percentile Documentation and Counseling for Nutrition measures. • THP achieved improvement in all Medicaid performance measure rates and statistically significant improvement in the Child and Adolescent Well-Care Visits (Total) measure. • THP's validation score was 100 percent.

UHP	
Topic	Immunizations for Adolescents
Performance Measure(s), Measure Steward, and Population	**PMs 1 and 2:** Immunizations for Adolescents - • Combination 2 • Human Papillomavirus (HPV) **Measure steward:** NCQA **Population:** Adolescents 13 years of age
Findings	• UHP reported its first remeasurement results for its Medicaid Immunizations for Adolescents - Combination 2 and HPV measures. • The MCO achieved improvement in both Medicaid measures. • UHP's validation score was 95 percent.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: Performance Measure

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

In an effort to uniformly measure MCO quality of care, BMS requires MCOs to report measures from nationally recognized measure sets such as CMS Adult and Child Quality Core Sets and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The NCQA maintains and directs the HEDIS® program.

Qlarant's role is to validate MCO performance measures, which is accomplished by:

- Evaluating the accuracy of the performance measures reported by (or on behalf of) an MCO.
- Determining the extent to which the performance measures followed the specifications for the measures.

Qlarant validated state-selected performance measures during the 2022 PMV activity. Designated HEDIS®, CAHPS®, and CMS Core Set measures were used to calculate MY 2021 MHT performance. The table below displays the MHT MCO MY 2021 Medicaid performance measure rates. The table reports each measure's data collection methodology for informational purposes, and includes the MHT MCO

Medicaid averages.

MHT MCO Medicaid Performance Measure Rates for MY 2021

Medicaid	ABHWV %	THP %	UHP %	MHT AVG %
Annual Dental Visit - Total (ADV)^	36.37	31.24	35.18	34.26
Child and Adolescent Well-Care Visits: 12-17 Yrs (WCV)^	52.22	44.55	NR	NA
Child and Adolescent Well-Care Visits: 18-21 Yrs (WCV)^	26.20	23.50	NR	NA
Child and Adolescent Well-Care Visits: 3-11 Yrs (WCV)^	NR	56.61	NR	NA
Child and Adolescent Well-Care Visits: Total (WCV)^	NR	47.19	NR	NA
Contraceptive Care – All Women Ages 15-20 LARC Method of Contraception (CCW-CH)	4.23	3.23	3.36	3.61
Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception (CCW-CH)	38.90	37.86	37.35	38.04
Contraceptive Care – All Women Ages 21–44 LARC Method of Contraception (CCW-AD)	3.27	3.28	3.08	3.21
Contraceptive Care – All Women Ages 21–44 Most or Moderately Effective Method of Contraception (CCW-AD)	22.80	21.58	23.68	22.69
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days (CCP-CH)	4.87	3.92	1.61	3.47
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 60 Days (CCP-CH)	13.72	11.11	13.23	12.69
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days (CCP-CH)	7.96	6.54	4.84	6.45
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 60 Days (CCP-CH)	54.42	40.52	45.81	46.92
Contraceptive Care – Postpartum Women Ages 21-44 LARC Method of Contraception 3 Days (CCP-AD)	2.98	2.47	1.96	2.47
Contraceptive Care – Postpartum Women Ages 21-44 LARC Method of Contraception 60 Days (CCP-AD)	10.27	8.98	9.30	9.52
Contraceptive Care – Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception 3 Days (CCP-AD)	19.66	15.22	15.58	16.82

Medicaid	**ABHWV %**	**THP %**	**UHP %**	**MHT AVG %**
Contraceptive Care – Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception 60 Days (CCP-AD)	49.95	42.75	44.52	45.74
Developmental Screening in the First Three Years of Life Age 1: Eligible children who had a screening on or before their 1st birthday (DEV)	22.29	62.57	22.12	35.66
Developmental Screening in the First Three Years of Life age 2: Eligible children who had a screening on or before their 2nd birthday (DEV)	19.82	58.45	19.41	32.56
Developmental Screening in the First Three Years of Life Age 3: Eligible children who had a screening on or before their 3rd birthday (DEV)	18.07	52.59	18.47	29.71
Developmental Screening in the First Three Years of Life Total: Total number of eligible children who had a screening in the 12 months on or before their 1st, 2nd, or 3rd birthday (DEV)	19.97	57.74	19.94	32.55
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up: 18+ (FUA)	51.09	53.09	53.68	52.62
Immunizations for Adolescents - Combination 2 (IMA)^	24.21	NR	32.12	NA
Immunizations for Adolescents - HPV (IMA)	NR	NR	32.60	NA
Percentage of Eligible (Children) that Received Preventive Dental Services (PDENT-CH)	44.88	42.92	44.82	44.21
PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) ***Lower rate indicates better performance***	10.95	22.49	14.03	15.82
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI05-AD) ***Lower rate indicates better performance***	24.45	36.76	26.46	29.22
PQI 08: Congestive Heart Failure (CHF) Admission Rate (PQI08-AD) ***Lower rate indicates better performance***	18.19	26.97	15.64	20.27
PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) ***Lower rate indicates better performance***	1.14	1.59	0.40	1.04
Screening for Depression and Follow-Up Plan - Ages 12-17 Years (CDF-CH) ***New measure***	3.10	0.98	1.23	1.77
Screening for Depression and Follow-Up Plan - Ages 18+ Years (CDF-AD) ***New measure***	2.17	1.23	2.17	1.86

Medicaid	ABHWV %	THP %	UHP %	MHT AVG %
Sealant Receipt on Permanent First Molars - Rate 1 - At Least One Sealant (SFM-CH) ***New measure***	48.71	37.56	48.71	44.99
Sealant Receipt on Permanent First Molars - Rate 2 - All Four Molars Sealed (SFM-CH) ***New measure***	31.33	24.31	29.88	28.51
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: 12-17 Yrs (WCC)	NR	81.15	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: 3-11 Yrs (WCC)	NR	81.46	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: Total (WCC)	NR	81.27	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: 12-17 Yrs (WCC)	NR	75.00	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: 3-11 Yrs (WCC)	NR	68.87	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Total (WCC)	NR	72.75	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: 12-17 Yrs (WCC)	NR	66.92	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: 3-11 Yrs (WCC)	NR	68.87	NR	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Total (WCC)	NR	67.64	NR	NA

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

Strategy: Test 24/7 PCP Availability

Confirmation it was conducted as described:

X Yes
___No. Please explain:

Summary of results:

The Code of Federal Regulations, 42 CFR §438.206 - Availability of Services, requires MCOs to make services included in their contracts available 24 hours a day, 7 days a week (24/7), when medically necessary. The table below includes the total percentage of 2022 provider surveys resulting in successful contact for each MCO. Surveys were deemed successful if contact was made with a live person, answering service, on-call provider, or recorded/automated message that identified the provider or practice.

Successful Contact Per MHT MCO for MY 2022

MY 2022 NAV	ABHWV	THP	UHP	MHT MCO AVG
Successful Contact	83%	87%	83%	84%

Unsuccessful surveys were due to:

- The phone number not reaching the intended provider (61%)
- Generic voicemail (25%)
- Other reasons (7%)
- Wrong location listed for provider (4%)
- No answer/no automated message (4%)

For each successful contact, Qlarant evaluated the provider's compliance with the 24/7 access requirement. The table below reports each MCO's rate of provider compliance; all MCOs achieved 100 percent for MY 2022.

MCOs demonstrated compliance through a recorded/automated message that directed enrollees to care (82%) or a live person who answered questions/directed enrollees to care (18%).

PCPs that were not accessible during Quarters 1-3 for 2022 surveys were resurveyed during Quarter 4. Prior to the resurvey, the MCOs had sufficient time to follow up with each provider and remedy any issue that prevented successful contact or compliance with directing enrollees to care during non-business hours and update their provider directories accordingly. Results of the resurvey, using the most current provider directories, are displayed below.

MY 2022 Resurvey Results

MY 2022 Resurvey	ABHWV	THP	UHP
Providers Requiring Resurvey			
Percentage of providers that were not accessible during quarters 1-3 2022 and required a resurvey	17%	13%	17%
Resurvey Results*			
Percentage of providers successfully contacted during Quarter 4 2022	80%	71%	50%
Percentage of successfully contacted providers that were compliant with 24/7 access requirement during Quarter 4 2022	75%	80%	80%

Note when interpreting results, percentages are based on small denominators.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

Strategy: Utilization Review

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results:

MCOs submitted quarterly utilization reports to the State from Q1 2022 through Q4 2022. Based on the information submitted in Q4 2022, the State had the following observations:

Outpatient Services:

- Aetna had an average of 4,585 Outpatient visits per 1,000 enrollees.
- UniCare had an average of 4,013 Outpatient visits per 1,000 enrollees.
- THP had the fewest average of 3,629 Outpatient visits per 1,000 enrollees.
- Across all of MHT for Q4 2022, there were 4,076 Outpatient visits per 1,000 enrollees.

ER Visits:

- UniCare had the greatest average of ER Visits during Q4, at 686 ER visits per 1,000 enrollees.
- Aetna had an average of ER Visits, at 674 ER visits per 1,000 enrollees.
- THP had the fewest average of 608 ER Visits per 1,000 enrollees.
- Across all of MHT for Q4 2022, there were 656 ER visits per 1,000 enrollees.

Delivery Utilization:

- Aetna reported 355 vaginal and 181 cesarean deliveries in 2022 Q4.
- THP reported 220 vaginal and 135 cesarean deliveries in 2022 Q4.
- UniCare reported 495 Vaginal and 251 Cesarean deliveries in 2022 Q4.

Physician Utilization:

- Aetna had an average of 7,901 physician visits per 1,000 enrollees.
- THP had an average of 7,823 physician visits per 1,000 enrollees.
- UniCare had an average 7,792 of physician visits per 1,000 enrollees.

Note that HHOWV began receiving membership August 2024; therefore, they are not included in this reporting cycle.

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

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: Mandy Carpenter

c. Telephone Number: 304-352-4222

d. E-mail: Mandy.D.Carpenter@wv.gov

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

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

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

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

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

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

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

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

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

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

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

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

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

a.___Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1.___First Year: per member per month fee
   2.___Second Year: per member per month fee
   3.___Third Year: per member per month fee
   4.___Fourth Year: per member per month fee

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.
For Initial Waivers only:

a.__ Population in the base year data

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

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

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

d.__ [Required] Explain any other variance in eligible member months from BY to 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 _____.

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. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. X For a renewal waiver, the previous two year waiver period included State Fiscal Year (SFY) 2022 (July 1, 2021 through June 30, 2022) and SFY 2023 (July 1, 2022 through June 30, 2023), as well as a ninety day extension period (July 1, 2023 through September 30, 2023). Because of the timing of the waiver renewal submittal, the State did not have a complete SFY2023 to submit. To ensure that R2 includes actual costs from a full year, R2 was set to Calendar Year 2022 (January 1, 2022 through December 31, 2022) and R1 was set to include the first six month of SFY 2022 (July 1, 2021 through December 31, 2021).

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

Enrollment projections were based on enrollment during SFY 2022.

SSI 0-18, SSI 19+, TANF pregnant women, TANF CSHCN, Traditional TANF, and ACA Expansion populations were identified based on the rate codes and

member ages applicable to these populations in the eligibility data for those members who are enrolled in the MCOs. Primary reasons for the decrease in member months from R2 to P1 and P1 to P2 is the continuing reversal of the eligibility verification suspensions and unemployment related to COVID public health emergency. The Pregnant women projections increase from R2 to P1 due to upcoming postpartum expansion to 12 months.

d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2:

Primary reason for the decrease in member months from R2 to P2 is the continuing reversal of eligibility verification suspension and unemployment related to COVID (explained above).

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

Due to the timing of the renewal application a full State Fiscal Year period was not available for R2. To ensure R2 includes a full year of data, R1 and R2 were defined as calendar years (CY). R1 is the last six months of Calendar Year (CY) 2021 (July 1, 2021 through December 31, 2021) and R2 is the full CY 2022 period (January 1, 2022 through December 31, 2022)

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**:

P1 and P2 services are comparable to R1 and R2 services. All services provided to waiver members are included in the cost-effective analysis..

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 provided to waiver members are included in the cost-effective analysis.

The capitation costs and separate FFS expenditures for R1/R2 have been developed using the quarterly CMS-64 reporting for the separate waiver

populations and eligibility groups. They were compared to the monthly MCO capitation rates for reasonability and adjusted for the R1 CSHCN population only.

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

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

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
N/A	*N/A*	*N/A*	*N/A*

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
N/A	*N/A*	*N/A*	*N/A*
Total	*N/A*	*N/A*	*N/A*

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
N/A	*N/A*	*N/A*	*N/A*
Total	*N/A*	*N/A*	*N/A*

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

c. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for

which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stop/loss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. X The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

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

d. ___ 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 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 rate setting regulations) *(i.e., trending from present into the future)*.

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

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

3.___The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 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:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*.
Others:

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

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

2.___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) A~~djustment:** 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 included from base year data.

2.___We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___Other (please describe):

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

1.___GME adjustment was made.
   i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
   ii.___GME rates or payment method is projected to change in the period between the beginning of P1 and the end of 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): N/A; pharmacy not included under MCO capitation arrangement

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

1.___We assure CMS that DSH payments are excluded from base year data.

2.___We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___Other (please describe):

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

1.___This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___This adjustment was made:
i.___ Potential Selection bias was measured in the following manner:
ii.___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.

1.___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.

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

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

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs

comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: 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. X Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1]

   See rationale below.

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 rate setting regulations) *(i.e., trending from present into the future)*.

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

   ii. X National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used:

   The Congressional Budget Office 10-year PMPY budget projections for Medicaid (separated for the following categories: aged, blind and disabled, children, adults-traditional eligibility categories, adults – made eligible by the ACA). Aged (FY22-23/FY23-24/FY24-25): -1.1%/-5.0%/3.0%; Blind and Disabled: 0.7%/-7.0%/4.1%; Children: 6.2%/-11.2%/4.8%; Adults - Traditional: 6.9%/0%/6.8%, Adults - ACA: 6.3%/8.7%/7.3%.

   Using the Blind and Disabled category as an example, for the R2 to P1 trends, 9 months of FY22-23 trends plus the complete 12 months of 23-24 were utilized = (1.0072^.75)*(0.9299)-1 = -6.5%. For P1 to P2, the FFY24-25 annual trends were utilized at 4.1%.

   https://www.cbo.gov/system/files?file=2022-05/51301-2022-05-medicaid.pdf

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.

For budget neutrality purposes for section 1115 waivers, CMS notes that the President's Budget trends are an appropriate benchmark to assess whether the waiver is at least as effective at controlling costs as national guidelines. "Limiting per capita cost trends to no more than the President's Budget trends reflects CMS's effort to align its approach to budget neutrality with federal budgeting principles and assumptions." Similarly, while this is a 1915b waiver, we believe it is appropriate to use the aged, blind and disabled, child, and adult per member per year trend rates per the CBO for FYs 2022-2025 as our selected benchmarks for projection purposes. We do not believe it is appropriate to solely use the State's historic trend experience in future years to assess cost effectiveness; this would mean the State would be expected to continually beat its historic trend experience. This is not appropriate as year over year managed care savings should be expected to decline for maturing programs. We assume the CBO trends reflect anticipated national changes such as technology, practice patterns, and units of service.

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

adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

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

i. X 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.

C. Determine adjustment based on currently approved SPA.

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

E. X Other (please describe):

We expect a 2.0% increase in cost for P1 and P2 due to expected changes in the 1115 waiver renewal and anticipated approval during 2023.

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., startup costs). Please explain:

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

A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment
D.___Other (please describe):

v.__ Changes in legislation (please describe):

For each change, please report the following:

A.__The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment
B.___The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment
C.___Determine adjustment based on currently approved SPA. PMPM size of adjustment
D.___Other (please describe):

vi.___Other (please describe):

A.___The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment
B.___The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment
C.___Determine adjustment based on currently approved SPA. PMPM size of adjustment
D.___Other (please describe):

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

1.___No adjustment was necessary and no change is anticipated.

2. X An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii. X Cost increases were accounted for.

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

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

C. X State Historical State Administrative Inflation.

The historical trend rate used in the previous renewal was 2% annually. Due to the current higher inflationary environment, we are assuming a 3.0% annual administrative increase for FFY2023 to FFY2025 and a 3.6% for FFY2022 to FFY 2023.

Please document how that trend was calculated:

Trend Months R2 to P1 = 21 months, P1 to P2 = 12 months, Annual Trend % = 3%

D.___ Other (please describe):

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

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

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

d. 1915(b)(3) Trend Adjustment: The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the

program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___[Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

   i. State historical 1915(b)(3) trend rates
      1. Please indicate the years on which the rates are based: base years _____
      2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
   ii. State Plan Service Trend
      1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above.

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

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

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

If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*: Rebates that

States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated. *Basis and Method:*

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3. __ Other (please describe):
   i. __ No adjustment was made.
   ii. ___ 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.

R2 was selected as the base period as it is the most recent 12 months of available data. R1 contains 6 months of earlier historical data and is therefore more susceptible to seasonality and other variances. The base period, state plan trend, state plan programmatic changes, and administrative cost adjustments are described above in section D4.

L.Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

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

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

N/A

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

   R1 to R2: R1 represents a 6-month time period and contains some seasonality not found in the full year of R2 data contributing to the rate of change. The overall R1 to P1 rate of change is minimal.

   R2 to P1: The annualized increase ties back to the increased inflationary environment for this period as well as national factors that are predictive of this waiver's future.

   P1 to P2: National factors that are predictive of this waiver's future.

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**:

   Please see above. 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.