Proposal for a Section 1915(b) Capitated Waiver Program

Waiver Renewal Submittal

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

July 1, 2021

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Table of Contents

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.
___ 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

_X_ 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
_X_ 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
_X_ 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 July 1, 2021 and ending June 30, 2023.

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 twelve waiver periods. The current waiver was approved for the period of October 1, 2019 to June 30, 2021. This waiver renewal request is for a 24-month period beginning July 1, 2021 and ending June 30, 2023.

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 2021 – 2023

- In the next waiver period, BMS intends to integrate 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.
- By January 2022, BMS also intends to integrate High Cost Drug Risk Corridor into the MHT program. BMS is currently developing a program approach and assessing the impact on operations, MCO rates, and cost effectiveness.
- During the waiver period, BMS will renew its focus on social determinants of health and strengthen these services.

2019 – 2021

- The WVCHIP program will obtain managed care authority under a State Plan Amendment, effective January 1, 2021 and was removed in this 1915(b) waiver renewal. The WVCHIP populations will remain under the Mountain Health Trust

program and sign 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 member 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, MAXIMUS 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 Mountain Health Trust 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 of the MCOs 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, which was implemented in April 2013, and children's dental, which 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 Mountain Health Trust

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

   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.):

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

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.

Members have a choice of three 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)):

The following table lists the 34 counties that meet the definition of "rural" and the current type of program in each county.

#	County	Qualifies as "rural"	Network currently approved by CMS for one plan enrollment
1	Barbour	Yes	Not needed
2	Braxton	Yes	Not needed
3	Calhoun	Yes	Not needed
4	Doddridge	Yes	Not needed
5	Fayette	Yes	Not needed
6	Gilmer	Yes	Not needed
7	Grant	Yes	Not needed
8	Greenbrier	Yes	Not needed
9	Hardy	Yes	Not needed

#	County	Qualifies as "rural"	Network currently approved by CMS for one plan enrollment
10	Harrison	Yes	Not needed
11	Jackson	Yes	Not needed
12	Lewis	Yes	Not needed
13	Logan	Yes	Not needed
14	Marion	Yes	Not needed
15	Mason	Yes	Not needed
16	McDowell	Yes	Not needed
17	Mercer	Yes	Not needed
18	Mingo	Yes	Not needed
19	Monroe	Yes	Not needed
20	Nicholas	Yes	Not needed
21	Pendleton	Yes	Not needed
22	Pocahontas	Yes	Not needed
23	Raleigh	Yes	Not needed
24	Randolph	Yes	Not needed
25	Ritchie	Yes	Not needed
26	Roane	Yes	Not needed
27	Summers	Yes	Not needed
28	Taylor	Yes	Not needed
29	Tucker	Yes	Not needed
30	Tyler	Yes	Not needed
31	Upshur	Yes	Not needed
32	Webster	Yes	Not needed
33	Wetzel	Yes	Not needed
34	Wyoming	Yes	Not needed

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

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

Mandatory enrollment of this population (excluding dual eligibles and those in residential settings and MR/DD waivers) in the previous waiver program was approved by CMS. 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

Members of this population will be 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 6 up to age 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 programs.

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, in so far as these requirements are applicable to this waiver.

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

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

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

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

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

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

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 beneficiary 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 members 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
438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

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

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

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

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

a.___ 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 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. Counselors conducting enrollment over the telephone record any health assessment information in this field. This data, along with copies of the health assessment forms, is 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 a list of the 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 ninety (90) 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 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.

__ 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	
		Provider Surveys to Assess 24/7 Access		X
		Encounter Data Validation		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):

10. 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, and
- Gifts to enrollees based on specific health events unrelated to enrollment (e.g., baby T-shirt showing immunization schedule).
- Marketing materials to potential members;
- Member 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 valued at or under $15 to potential MCO enrollees. The MCO may not provide gifts to providers to distribute to potential members, unless such gifts are placed in the providers' office common areas and are available to all patients.

   After enrollment, pertinent items (e.g., magnet with immunization schedule) MAY be approved by the State, but must be pre-approved. MCOs may only issue gift cards to members 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):

Currently no language other than English is spoken by more than 1% of the population. On an ongoing basis, the State reviews reports generated from the eligibility system, which records demographic information such as primary language at the time of the application, to determine prevalent languages. Within ninety (90) calendar days of notification from DHHR, the MCO will make written materials available in prevalent non-English languages in its service areas.

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%.

The State considers any language spoken by 5% or more of the population to be significant; currently no language other than English is spoken by more than 1% of the population. On an ongoing basis, the State reviews reports generated from the eligibility system, which records demographic information such as primary language at the time of the application, to determine prevalent languages.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

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

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

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

2. Details.

a. Non-English Languages

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

The State does not require translation of enrollee materials into any other languages as English is the primary language spoken by 99.9% of enrollees. However, the State's enrollment broker offers translation services in its call center for over 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 with a translation service (Language Line) that can 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.

The MCO is 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 MCO must also provide audiotapes for the illiterate upon request.

BMS will periodically review the degree to which there are any prevalent language or languages spoken by Medicaid beneficiaries in West Virginia (cultural groups that represent at least five percent (5%) of the Medicaid population). Within ninety (90) calendar days of notification from BMS, the MCO will make written materials available in prevalent non-English languages in its service areas. At the current time, there is no data to indicate that West Virginia has any Medicaid populations that meet this definition.

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 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, at least for 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.

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. Also, the Guide to Medicaid is available to all enrollees and potential enrollees at the local DHHR offices. The Guide to Medicaid can be accessed at

https://dhhr.wv.gov/bms/Documents/Guide%20to%20Medicaid%202020FinalApproved.pdf

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

_X_ State

_X_ contractor (please specify):

MAXMIUS Health Services, Inc. (MAXIMUS) is the state's contracted Enrollment Broker organization.
The DHHR office provides all enrollees or potential enrollees information about the managed care programs and options through the Guide to Medicaid. The enrollment broker provides additional information specific to the MCO programs. The Guide to Medicaid can be accessed at https://dhhr.wv.gov/bms/Documents/Guide%20to%20Medicaid%202020FinalApproved.pdf. The Enrollment Broker provides additional information specific to the MCO programs in 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

The 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 MCO must ensure that enrollees have access to the most current and accurate information concerning the MCO's network provider participation.

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

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

The MCO 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. The MCO must notify beneficiaries annually of their right to request and obtain a provider directory. Additionally, the MCO must deliver an update of the provider directory on disk to the enrollment broker every month. The MCO must provide potential enrollees a copy of the provider directory, upon request. The MCO must publish and keep current its provider directory on the MCO website. The MCO must provide enrollees a copy of its provider directory, upon request within five (5) business days. MCOs shall submit the provider directory 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 US Health Services, Inc (Maximus), of newly eligible persons and adds them to the enrollment broker's mailing list. The enrollment broker provides outreach and education to potential enrollees and is responsible for making outreach calls to potential enrollees with valid telephone numbers, , when applicable. The enrollment broker has two units: the call center, which staffs the toll-free telephone line, and outreach field staff, who provide outreach and education around the state.

Outreach is a key component of the enrollment process. The enrollment broker staff attempt to contact every potential enrollee. A welcome packet is mailed to each newly eligible member. For members who have not made a choice after 15 days, a reminder letter is mailed to the member, to avoid auto-assigning the beneficiaries. 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.

When there are program changes related to Mountain Health Trust local DHHR offices are contacted by the Outreach and Education Specialist (OES) to provide relevant updates and trainings. In-service trainings are scheduled with DHHR staff as needed. In an effort to connect with Medicaid members directly, field staff may set up an informational table in the DHHR lobby, especially in the case of changes to MCO availability within a particular county. Local DHHR office staff will also provide the member with a brochure and/or the 1-800 number for referral. DHHR offices can also contact the OES to request meetings with individuals or to advise of any issues or questions.

Enrollment broker staff attend meetings with key stakeholders in the community, including agencies working directly with potential enrollees, to help to enrollees about MHT. At these meetings, enrollment broker staff 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; if the OES and organization can schedule an educational session for potential enrollees, the OES will attend and present.

The OES utilize other venues such as libraries, food pantries, clothing closets, laundromats, and grocery stores to display information on the MHT program. 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 web.

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. At these events staff distribute brochures, 1-800 cards, and answering 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. Individuals with special needs can utilize website a screen reader technology to assist in reviewing material. 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. In Maximus' experience, provider offices are key outreach locations, as they can direct their patients to Maximus for enrollment or MCO provider changes. OES will leave MHT program brochures with the Maximus toll-free helpline number for their patients.

The individual MCOs provide education to community providers on their role in the MHT program. The enrollment broker provide in-service trainings for MCO staff that 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 provide 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 Health Services, Inc., 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 beneficiaries' 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.

Approximately fourteen (14) days after the welcome packet is sent to a potential enrollee, the enrollment broker will send a reminder letter to individuals who have not yet made a 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 plan choice again via phone or mail.

Individuals who have still not made a plan selection by the 30th 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 auto assignments are provided to the fiscal agent by the enrollment broker in a file transfer.

Any individuals who contact the enrollment broker with a plan selection after the auto-assignment and before cut-off will be changed to the plan of their choosing. After cutoff, the state's fiscal agent reconciles the enrollment information with the updated enrollment broker data. Any assignments (choice or automatic) are scheduled to become effect the first 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 back to the plan he/she was previously enrolled once they are determined eligible.

All materials sent by the enrollment broker to enrollees or potential enrollees throughout the process described above are written at a sixth grade reading level.

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 Mountain Health Trust 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 can change PCPs or managed care organizations 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 beneficiaries who are children (aged 0-19 years) are granted 12 months *continuous* 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.

Beneficiaries, including persons with special health care needs, who lose and regain eligibility for enrollment in Mountain Health Trust within one year, are auto-assigned to their previous MCO. If the person has been disenrolled for more than one 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

The MCO may not involuntarily disenroll any member except as specified below:

- Loss of eligibility for Medicaid or for participation in Medicaid managed care, including becoming a Medicare beneficiary
- Failure of the State to make a premium payment on behalf of a member (West Virginia insurance regulations require that MCOs be permitted to disenroll a member if the payer fails to make premium payments for that member)
- The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must immediately re-enroll into a new MCO.

- Continuous placement in a nursing facility, State institution or intermediate care facility for intellectual/ developmental disabilities for more than 30 days
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary 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 beneficiary while their exemption request was being considered.
- Upon the beneficiary's death

The MCO 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 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 recipient 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 Care)	(Coverage and Authorization, Provider Selection, Quality of

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												
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												
Geographic mapping							X	X				X
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
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												
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: Guidehouse

Description: MCOs are required to keep current NCQA accreditation for their Medicaid lines of business. Any new MCO entering the MHT program must apply for NCQA accreditation no later than nine months from its operational start date in the MHT program. MCOs submit their accreditation status reports to BMS for review.

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:

MCOs are required to annually conduct adult and child member satisfaction surveys using the latest version of the Consumer Assessment of Health Plans Survey (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 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.

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 the members or providers. If any areas of need are identified they are discussed with the State, which provides a plan to the enrollment broker's Outreach and Education Specialists to ensure proper program education is provided. In addition, data is used to increase education of the program, which ultimately increases member choice enrollments. 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. Data informs areas including choice, information to beneficiaries, timely access, PCP and specialist capacity, coordination and continuity, and provider selection.

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:

All enrollments and disenrollments are processed by the State's enrollment broker. Information on the reasons for MCO changes are recorded monthly and are monitored by the enrollment broker and the State. The enrollment broker produces monthly reports that track all enrollment changes which are provided to the Director of Managed Care. The broker tracks all requests for enrollment and categorizes them as follows:

•Doctor recommended

•Provider not in plan

•Enrollee moves out of MCO service area

•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 determine if there are any underlying problems with access or quality of care. If trend analysis proves that there are 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 monitor program impact and 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 five areas – access, attitude / services, billing / financial, quality of care, and quality of practitioner office site. The MCOs also report the number of denials and appeals. MCOs categorize denials into five areas including: not a covered benefit / benefit exhausted, not medically necessary, provider out of network, systems / program issues, and unknown. MCOs categorize appeals into four areas including: medical including vision, dental, behavioral health, and pharmacy. The EQRO provides a summary of these grievances 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 which 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.

PCP Termination Rates and Reasons

Responsible Party: MCO

Description:

MCOs are required to submit quarterly reports with a list of their PCP providers and panel sizes, and any additions or terminations. After enrollment of SSI enrollees in the upcoming waiver period, MCOs will submit similar reports for providers serving SSI enrollees. The MCO must provide BMS and the enrollment broker with advanced written notice of any PCP network deletions within 14 days.

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

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. The MCO must provide

BMS and the enrollment broker with advanced written notice of any PCP network deletions within 14 days. The MCOs report any disenrollment of hospitals from the MCO's network to BMS immediately.

The MCOs also submit information on network changes quarterly. 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.

Financial data

Annually, on or before March 1st, 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 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. 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

How the Activity Yields Information on the Areas Being Monitored: Periodic MCO reporting providers monitoring over program integrity and data accuracy.

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 of the program, which ultimately increases member choice enrollments.

e. __ 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).

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: Guidehouse

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 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.

MCOs must also report significant changes in networks to the State, at which point plan and county specific analyses are conducted to ensure provider network standards are still being met.

Frequency: Annually

How the Activity Yields Information on the Areas Being Monitored: Geographic mapping providers oversight of provider network capacity and access for applicable provider specialties.

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

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

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 beneficiaries in a new service area, prior to enrolling a new population, prior to implementing a new benefit, on an ongoing basis through quarterly reporting, and immediately at any time there has been a significant change in the existing provider network that affects access and capacity.

MCOs that wish to begin enrolling beneficiaries in a new service area or in a new population must establish and maintain provider networks in geographically accessible locations for the populations to be served. 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 their 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. X Ombudsman

Responsible Party: State

Description:

Per West Virginia *Code* §49-9-101 et seq, the program will have a dedicated Ombudsman who will be housed within the West Virginia Office of the Inspector General. In addition, the MCO is required to have a Medicaid Member Advocate to assist members with filing grievances and addressing any other concerns.

Frequency: Annually in the first year; quarterly thereafter

How the Activity Yields Information on the Areas Being Monitored: BMS' partnership with the Ombudsman Office allows the State to monitor provider choice, enrollment / disenrollment, information to beneficiaries, grievances, and provider selection.

k. _X_ On-site review

Responsible Party: Qlarant

Description:

The State's EQRO conducts an annual on-site review of each MCO's administrative and operational systems to ensure that the MCO has the appropriate structure in place to meet all program requirements. Onsite review was completed in March 2020. Compliance with service provision requirements regarding family planning services, emergency care services, and FQHC-based services are also part of the review.

The 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). 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 a three year schedule ensuring a comprehensive review within the CMS-mandated timeframe. For the 2020 SPR, the EQRO reviewed: 438.10 - Information Requirements, §438.206-§438.207 - Availability of Services & Assurance of Adequate Capacity and Services, and §438.330: Quality Assessment and Performance Improvement Program. The 2020 SPR evaluated MY 2019 compliance. Qlarant completed review activities in a manner consistent with CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations. The SPR process was interactive with the MCO. The EQRO conducts the SPR in three phases: pre-site, on-site, and post-site. The pre-site phase includes a review of 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. The on-site phase is conducted 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. Onsite visit activities occurred during March 2020. Please refer to the State Strategy for Assessing and Improving Managed Care Quality, for more detail on the EQRO scope of work.

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, and
• 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, and
• Effectiveness of communications with enrollees.

MCOs are required to maintain at least three 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 project can be discontinued. 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 submitted their reports to the EQRO in July 2020 after MY 2019 performance measure rates were finalized. MCOs completed a data and barrier analysis and identified follow-up activities for each PIP submission. MCOs used Qlarant reporting tools and worksheets to report their PIPs. Qlarant provided MCO- specific technical assistance, as requested. The State's EQRO conducts an annual review of each MCO's indicated performance improvement projects utilizing the CMS protocol, Validating Performance Improvement Projects—A Project for Use in Conducting Medical External Quality Review Activities. An annual report is completed for each MCO and an aggregate report is produced 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: Annual

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 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:

Process

Health status/outcomes

Access/availability of care

Use of services/utilization

Health plan stability/financial/cost of care (Guidehouse is responsible party)

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: enrollment / disenrollment, grievances, timely access, PCP / Specialist capacity, coverage / authorization, quality of 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: Guidehouse

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. __ Other: (please describe)

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 here: http://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Documents/Managed%20Care%20Health%20Plan%20Accreditation%20Status%20for%20West%20Virginia_12.16.20_v2.pdf.

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 adults and children enrolled in each MCO in 2019. Two distinct populations were surveyed – adults and children in managed care. 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. The surveys were conducted on behalf of the MCOs by NQCA-certified vendors.

Results

Overall CAHPS results from 2019 survey were mixed for MCO members. On questions relating to care and communication, the MHT average rate met or exceeded the NCQA Quality Compass National Medicaid Average for each measure (see #s 1, 2, and 3 in the table below) for adults and met or exceeded the NCQA Quality Compass 75th percentile for each measure for children. Results for ratings of members' specific providers or plan were less favorable, with many measures for MHT adults and children falling below the NCQA Quality Compass average. Findings to date for these members are detailed in the table below.

Table: West Virginia 2020 CAHPS (MY 2019) Measures

		MHT Weighted MY 2019 Average %	
	Survey Findings for MCO Members	**Adult MCO**	**Child MCO**
	Percent of members who always or usually get routine care as soon as they thought they needed	86.00	95.87
	Percent of members who always or usually get the care they needed right away as soon as they thought they needed	87.39	91.43
	Percent of members who said that doctors and other providers always or usually explained things in a way they could understand	93.67	97.29
	Percent of members who rated their health plan an "8" or higher on a 10-point scale	75.24	85.20
	Percent of members who rated their health care an "8" or higher on a 10- point scale	71.09	86.31
	Percent of members who have a personal doctor or nurse and rated them an "8" or higher on a ten point scale	83.57	91.60
	Percent of members who saw a specialist and rated their specialist 8 or higher on a 10 point scale	80.12	N/A

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

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.

In the MCO program, enrollees may switch from one MCO to another at any time, for any reason.

MCO Changes Over the Last Waiver Period

		MHT Enrollees	
Year	**Month**	**Number of Changes**	**Percent of Enrolled**
2019	Oct	815	0.20% (Less than 1%)
	Nov	771	0.19% (Less than 1%)
	Dec	622	0.15% (Less than 1%)
2020	Jan	700	0.17% (Less than 1%)
	Feb	845	0.20% (Less than 1%)
	Mar	392	0.09% (Less than 1%)
	Apr	290	0.07% (Less than 1%)
	May	444	0.10% (Less than 1%)
	Jun	560	0.13% (Less than 1%)
	Jul	409	0.09% (Less than 1%)
	Aug	517	0.12% (Less than 1%)
	Sep	518	0.12% (Less than 1%)
	Oct	735	0.16% (Less than 1%)
	Nov	254	0.05% (Less than 1%)
	Dec	439	0.09% (Less than 1%)

Beginning in March 2020, the monthly number of changes in enrollment decreased on average while total monthly MCO enrollment increased on average, resulting in a lower monthly disenrollment figure as a percentage of enrollees.

Grievances, Appeals and Denials

MCOs submit their grievance, denial, and appeal “universes” to Qlarant on a quarterly basis. Qlarant collected all information and selected random sample records for each category. MCOs were notified of the selected sample and they provided the full records to Qlarant for review and validation activities.

Qlarant examined records and evaluated MCO compliance with federal and state requirements. 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.

MCOs have 90 calendar days to resolve grievances. Therefore, MCOs did not submit their grievance, denial, and appeal universes to Qlarant until approximately 105 days after the quarter ended. Reporting of record reviews only captures results based on quarters 1 and 2 of 2020. Implemented in 2020, this a new activity and previous annual results are not available.

The table below includes MHT MCO grievance, denial, and appeal results for two quarters of 2020. Results are displayed by MCO and by MHT MCO average for each category.

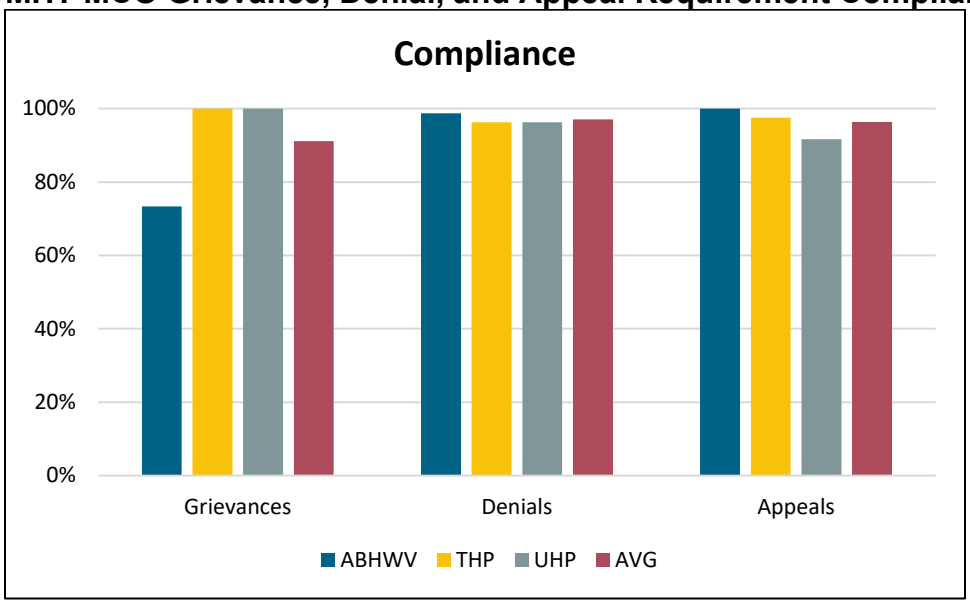
MHT MCO Grievance, Denial, and Appeal Requirement Compliance for Q1-Q2 2020

	ABHWV Compliance	THP Compliance	UHP Compliance	MHT MCO AVG Compliance
Grievances	73%	100%^	100%	91%
Denials	99%	96%	96%	97%
Appeals	100%	98%^	92%	96%

^ At least one quarter had less than 10 grievances or appeals

The figure below graphically displays MHT MCO 2020 results for the grievance, denial, and appeal reporting. All MHT MCO averages exceed 90% compliance.

MHT MCO Grievance, Denial, and Appeal Requirement Compliance for Q1-Q2 2020



At the time of this reporting, only partial year results for 2020 are available due to the lag in reporting which permits 90 days to resolve grievances. Qlarant's record reviews for quarters 1 and 2 2020 concluded the following:

- The grievance MHT MCO average compliance rate was 91% with MCO performance ranging from 73% (ABHWV) to 100% (THP and UHP).
- The denial MHT MCO average compliance rate was 97%. MCO compliance ranged from 96% (THP and UHP) to 99% (ABHWV).
- The appeal MHT MCO average compliance rate was 96% with MCO performance ranging from 92% (UHP) to 100% (ABHWV).

Additionally, Qlarant conducted a study of Grievance, Appeal, and Denial (GAD). Qlarant recorded MCO self-reported volume by category on a quarterly basis with the following results:

Detailed Grievance Categories:

Grievance Category	Q1 2020	Q2 2020	Q3 2020	MHT Total 2020
Access	48	12	9	69
Attitude/service	19	23	51	93
Billing/financial	114	122	98	334
Quality of care	9	5	5	19
Quality of Practitioner Office Site	0	0	0	0
Total	**190**	**162**	**163**	**515**

Denials of referral requests:

Denial Category	Q1 2020	Q2 2020	Q3 2020	MHT Total 2020
Not a Covered benefit/benefit exhausted	242	180	279	701
Not medically necessary	5055	2726	6237	14018
Provider out of network	315	159	409	883
Systems/Program Issues (including coverage by another entity)	36	9	27	72
Unknown (MCO did not define)	1398	0	0	1398
Total	**7046**	**3074**	**6952**	**17072**

Appeals by Service Type:

Appeals	Q1 2020	Q2 2020	Q3 2020	MHT Total 2020
Behavior Health	5	1	12	18
Dental	34	9	10	53
Medical including vision	144	52	175	371
Pharmacy	9	0	1	10
Grand Total	**192**	**62**	**198**	**452**

PCP Termination Rates and Reasons

MCOs provide provider termination notices as a line items on the quarterly report. Plans 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.

Periodic MCO Reporting

Provider network and utilization are included in other sections of this monitoring results update.

The State reviews periodic 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 Q3 2020, Aetna had the highest percentage of new enrollees auto-assigned to a PCP at 74.8%, THP auto-assigned 63% and UniCare auto-assigned 45.5%.
- **Financial data**: Aetna reported a 9.3% increase in total revenue from Q2 to Q3 of 2020, THP reported 0.3% and UniCare reported 12% 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; Guidehouse 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.

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 determined there to be any access or quality concerns with the enrollee hotline.

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:

__ Yes
_X_ No. Please explain: BMS did not detect any monitoring issues in need of a focused study during the waiver period.

Summary of results: N/A
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:

In addition to evaluation of provider networks prior to service area, benefit, and population expansions, the State reevaluates MCO network adequacy for all service areas annually. In 2020, 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 different provider types throughout the service area. 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 need to ensure they are submitting 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): If timelines are not met, liquidated damaged can be enforced.

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 enough 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).

Each of the three MCOs were fully compliant with requirements for urban hospital network, behavioral health provider network, and essential community provider (ECP) network. However, some MCOs did not meet compliant requirements for PCP network, dental network and substance use disorder (SUD) provider network due to missing data or network inadequacies in a couple counties. MCOs also encountered some challenges in meeting requirements for OB/GYNs or Certified Nurse Midwife (CNM)s in certain areas of the State.

Problems identified: Analysis of provider network adequacy revealed some 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.

Corrective action (plan/provider level): While BMS is in the process of reviewing network adequacy exceptions and evaluating the need for corrective actions plans to address gaps in the provider network, BMS and the MCOs are working to ensure that MHT members have the appropriate access to care including through out of network referrals.

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

Strategy: Ombudsman

Confirmation it was conducted as described:

__ Yes
_X_ No. Please explain: The first edition of the Ombudsman report is in development and not available at the time of this waiver renewal submission. The first Ombudsman report will reflect the first year of reporting, subsequent reports will be available on a quarterly basis.

Summary of results: N/A

Problems identified: N/A
Corrective action (plan/provider level): N/A
Program change (system-wide level): 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 with an EQRO that will conduct all three mandatory activities annually. Based on the on-site visit conducted in March 2020, the EQRO identified the following results:

- The MHT MCOs received overall PMV ratings ranging from 99%-100%. The MHT MCO average was 100%, providing high confidence in MCO performance measure calculations and reporting.
- An analysis of MY 2019 MHT MCO weighted averages demonstrates 50% of measures (9 of 18) met or exceeded national average benchmarks. The following measures met or exceeded the 75th percentile benchmarks:
    - Dental Sealants for 6-9 Year Old Children at Elevated Risk
    - Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up
    - Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
    - Congestive Heart Failure (CHF) Admission Rate
    - Asthma in Younger Adults Admission Rate
- Twelve (12) of 18 measures had rates available for MYs 2017-2019 and allowed for a trending analysis. Fifty-eight percent (58%) or 7 of 12 measures demonstrated a positive trend. Only 1 measure demonstrated a negative trend. The remaining measures did not produce a trend.

Systems Performance Review (SPR)

MCOs must achieve full compliance for all standards. MCOs not achieving 100% on any of the 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) 2019. Results for the three MHT MCOs that were operational for the full measurement year are presented in the table below. The MY 2020 compliance rates will be available in June 2021.

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 2020, assessed each MCO's measurement year (MY) 2019 compliance with federal and state regulations and requirements as it served the

West Virginia Medicaid population.

Table: MY 2019 MCO SPR Scores by Standard

SPR Standard Reviewed in 2020	ABHWV	THP	UHP	MHT MCO Average
Information Requirements	100%	100%	100%	100%
Availability of Services & Assurance of Adequate Capacity and Services*	100%	97%	86%	94%
Quality Assessment and Performance Improvement Program	100%	100%	93%	98%
Overall Weighted Score	100%	99%	94%	98%
Level of Confidence	High Confidence	High Confidence	Moderate Confidence	High Confidence

The MHT MCOs received overall weighted scores ranging from 94%-100% for the 2020 SPR evaluating MY 2019 compliance. The MHT MCO average was 98%. Stakeholders can have high confidence in ABHWV and THP's level of compliance and moderate confidence in UHP's level of compliance.

Problems identified: Of the three standards reviewed in 2020, one MCO achieved full compliance while two MCOs fell below full compliance on one or more standards.

Corrective action (plan/provider level): Both THP and UHP were required to develop corrective action plans (CAPs) for the elements/components not meeting full compliance; THP had one CAP and UHP had six CAPs across two standards. All CAPs were closed or resolved during 2020.

Strategy: Performance Improvement Projects

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

The State requires three performance improvement projects (PIPs). 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. The validation was completed 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 provided an individual evaluation for each PIP and provided educational opportunities, where appropriate, to the MCO for use in improving its PIPs. The following describes the

most recent performance improvement projects 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

MCO	PIP Topics, Description, and Goals	Update
Mandated	Annual Dental Visits - Will implementation of targeted educational and outreach interventions increase the rate of annual dental visits for members 2-3 years old?	• The MHT MCOs reported their second remeasurement rates for the Annual Dental Visits PIP. • The MCO weighted averages demonstrated sustained improvement in both PIP measures, Annual Dental Visits for 2-3 Year Olds and Percentage of Eligibles that Received Preventative Dental Services.[1] • The MCOs received an average PIP validation score of 94%, indicating (overall) stakeholders can have high 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 88%-100%.
Mandated	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - Will implementation of multi-faceted member, provider, and MCO interventions improve the annual Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Day Follow-Up) rate for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence?	• The MHT MCOs reported baseline measurement rates for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP. • The MCOs received an average PIP validation score of 97% (high confidence). Individual MCO validation scores ranged from 95%-100%.
ABHWV	Care for Adolescents - Will multipronged interventions improve annual rates of adolescent care including	• ABHWV reported baseline results for its Care for Adolescents PIP measures, Immunizations for Adolescents (Combination 2) and Adolescent Well Care Visits.

[1] Sustained improvement means all remeasurements demonstrated improvement compared to baseline performance.

MCO	PIP Topics, Description, and Goals	Update
	immunizations and well visits for members 9-21 years of age?	• ABHWV's validation score was 100% (high confidence).
THP	Promoting Health and Wellness in Children and Adolescents - Will system-level interventions focusing on children and adolescent well-being increase rates for the Adolescent Well Care Visits and BMI Percentile Documentation and Counseling for Nutrition measures by 10 percentage points over the course of the PIP?	• THP reported remeasurement two results for its Promoting Health and Wellness in Children and Adolescents PIP measures: Adolescent Well Care Visits, BMI Percentile Documentation, and Counseling for Nutrition. THP improved in one measure, BMI Percentile Documentation. • THP's validation score was 95% (high confidence).
UHP	Follow-Up After Hospitalization for Mental Illness - Will member, provider, and MCO-targeted interventions improve follow-up compliance for members hospitalized with select mental illness diagnoses? The MCO aims to demonstrate statistically significant improvement by the 2nd remeasurement year and to exceed the NCQA Quality Compass National Medicaid Average plus 5 percentage points for each measure.	• UHP reported remeasurement four results for its Follow-Up After Hospitalization for Mental Illness PIP measures, Follow-Up within 7 Days and 30 Days. UHP demonstrated sustained and statistically significant improvement in both measures. • UHP's validation score was 92% (high confidence).

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

All three MHT MCOs (ABHWV, THP, UHP) were required to participate in the PMV activities for MY 2019. The participating MCOs successfully reported all performance measures required by BMS (HEDIS, Adult and Child Core Measure Sets, and CAHPS). The eighteen required measures are:

- Adolescent Well-Care Visits
- Annual Dental Visits for 2-3 Year Olds
- Behavioral Health Risk Assessment for Pregnant Women
- Childhood Immunization Status: Combination 3
- Comprehensive Diabetes Care: HbA1c Testing
- Dental Sealants for 6-9 Year Old Children at Elevated Risk
- Follow-Up after Hospitalization for Mental Illness: 7 Days Follow-Up
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation Total
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Mental Health Utilization: Any Service Total
- Percentage of Eligible (Children) that Received Preventive Dental Services
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
- PQI 08: Congestive Heart Failure (CHF) Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate

- Prenatal and Postpartum Care: Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

The eighteen performance measures that were validated for MY 2019 can be used to assess performance on the dimensions of quality, access, and timeliness as required by the federal regulations. The EQR uses a diamond rating system to compare the MHT Weighted Averages (MHT-WAs) to the National Medicaid Percentiles (NMPs).

Quality Performance Measures

Four performance measures for MY 2019 were selected to assess performance for quality of care. The measures include:

- Childhood Immunization Status- Combination 3
- Comprehensive Diabetes Care – HbA1c Testing
- Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit
- Follow-Up After Hospitalization for Mental Illness – 7 Days Follow-Up

Table: Quality-Related Performance Measures MY 2018-2019 Weighted Average

Measure	MY 2018 %	MY 2019%
Childhood Immunization Status – Combination 3	69.07	71.28
Comprehensive Diabetes Care – Eye Exam	NR	45.04
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	75.71	75.37
Follow-Up After Hospitalization For Mental Illness - Follow-Up Visit Within 30 Days of Discharge (Total)	NR	57.04

Access Performance Measures

Six measures validated for MY 2019 were selected to assess performance for access of care. The measures include:

- Annual Dental Visits for 2-3 Year Olds
- Prenatal and Postpartum Care-Postpartum Care
- Percentage of Eligible (Children) That Received Preventive Dental Services
- Dental Sealants for 6-9 Year Old Children at Elevated Risk

Table: Access-Related Performance Measures MY 2018 – MY 2019 Weighted Average

Measure	MY 2018 %	MY 2019 %
Annual Dental Visits for 2-3 Year Olds	38.25	40.06
Prenatal and Postpartum Care - Postpartum Care	65.03	72.14
Percentage of Eligible (Children) That Received Preventive Dental Services	47.85	47.34
Dental Sealants for 6-9 Year Old Children at Elevated Risk	29.69	40.21

Timeliness Performance Measures

Six measures validated for MY 2019 were selected to assess performance for timeliness of care. The measures include:

- Adolescent Well-Care Visits
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate

Table 3 provides the MHT-WAs for three years and comparison to national benchmarks.

Table: Timeliness-Related Performance Measures MY 2018-2019 Weighted Average

Measure	MY 2018 %	MY 2019 %
Adolescent Well-Care Visits	59.88	62.95
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	75.38	76.96
PQI 01: Diabetes Short-Term Complications Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	22.44	20.93
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	64.35	43.50
PQI 08:Congestive Heart Failure (CHF) Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	17.83	18.00
PQI 15: Asthma in Younger Adults Admission Rate (Observed rate per 100,000 member months)	2.45	1.40

(lower rate is better)		

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 Q3 2019 through Q3 2020. Based on the information submitted in Q3 2020, the State had the following observations:

Outpatient Services:

- Aetna had the highest weighted average of Outpatient visits, at 2,918 admits per 1,000 members
- THP had an average of 2,239 admits per 1,000 members
- UniCare had the fewest amount of Outpatient visits over the year, at 1,567 admits per 1,000 members
- Weighted average across all of MHT was 2,212 admits per 1,000 members

ER Visits:

- UniCare had the greatest amount of ER Visits over the year, at 506 admits per 1,000 members
- THP had an average of 500 admits per 1,000 members
- Aetna had the fewest amount of ER Visits over the year, at 495 admits per 1,000 members
- The weighted average across all of MHT was 500 admits per 1,000 members.

Delivery Utilization:

- Aetna reported 17.0 vaginal and 9.2 cesarean deliveries per 1,000 in 2020Q3
- THP reported 30.5 vaginal and 14.9 cesarean deliveries per 1,000 in 2020Q3
- UniCare reported 16.2 Vaginal and 8.0 Cesarean deliveries per 1,000 in 2020Q3

Physician / Clinic Utilization:

- *Physician*:
    - In 2020Q3, physician visits for members of Aetna were 2,692 per 1,000 with an annual trend of -6.2%

    - Physician visits for members of THP were 2,747 per 1,000 with an annual trend of 103.9%
    - Physician visits for members of UniCare were 2,164 per 1,000 with an annual trend of -19.5%
- *Clinic*:
    - In 2020Q3, clinic visits for Aetna were 1,120 per 1,000 members with an annual trend of -4.8%
    - Clinic visits for THP were 679 per 1,000 members with an annual trend of -28.4%
    - Clinic visits for UniCare were 1,008 per 1,000 members with an annual trend of -23.1%

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: Becky Manning

c. Telephone Number: 304-356-4896

d. E-mail: Becky.A.Manning@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 <u>same</u> population as to be included in the waiver.
   2. ___ Base year data is from a <u>comparable</u> 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.

Note that Jan-Feb 2020 enrollment included in R2 was still under FFS.

b._X_For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.* Formulas were updated accordingly in the Summary tab.

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 for the quarter ended 12/31/20. SSI, TANF pregnant women, TANF CSHCN, Traditional TANF, and ACA Expansion populations were identified based on the rate codes applicable to these populations in the eligibility data for both those members who are enrolled in the MCOs. Primary reasons for increase in member months from R2 to P1 is residual impact of eligibility verification suspensions and unemployment related to COVID public health emergency. The decrease in member months from P1 to P2 results from the gradual reversal of the eligibility verification suspensions and unemployment related to COVID public health emergency.

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

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

R1 represents State Fiscal Year (SFY) 2020 (July 1, 2019 – June 30, 2020) and R2 represents the first half of SFY 2021 (July 1, 2020 – December 31, 2020).

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 except for an adult dental benefit added January 1, 2021. The adjustment is included in the PMPM Program Adjustment calculations on Appendix D5.

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 for R1/R2 have been developed by applying in-force capitation rates by actual MCO enrollment and delivery payments given the CMS-64 reporting contains many retroactive capitation changes for prior periods that are difficult to isolate. Directed Payments have been added to these amounts allocated by MEG. FFS expenditures for carved out services were pulled from mini-monthly reporting. This methodology results in a more reasonable assessment of annual costs for the program.

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

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

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

i. State Plan Service trend

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

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

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

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant

utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___We assure CMS that GME payments are 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:

   CBO 10-year PMPY budget projections for Medicaid (separated for the following categories: aged, adult, blind and disabled, children). Aged (FY20-21/FY21-22/FY22-23): 3.3/2.4%/3.2%; Blind and Disabled: 5.5%/4.2%/5.1%; Children: 6.5%/5.1%/5.5%; Adults: 6.0%/5.3%/5.5%.

   Using the Aged category as an example, for the R1 to P1 trends, 12 months of 21-22 trends plus 6 months of 22-23 were utilized = (1.0238)*(1.0325^.5)-1 = 4.47%. For P1 to P2, the FFY22-23 annual trends were utilized @ 3.2%.

   https://www.cbo.gov/system/files/2020-03/51301-2020-03-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 an 1915b waiver, we still 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 2019-2023 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 that that 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._X_The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment P2 = $19.95 PMPM for projected increase of directed payment pool in SFY22

C. X Determine adjustment based on currently approved SPA. PMPM size of adjustment__ P1 = $18.32 Primary reasons for the increase are additions for Adult Dental, Long Term Acute Care, Inpatient DRG increases, and COVID costs related to COVID member treatment/testing/vaccination administration fees.

After CMS RO preliminary review of the Cost Effectiveness schedules, WV was instructed to revise the waiver P1 and P2 Cost Projections. The revisions accomplish allocating the Directed Payments to all MEGs. In the original Cost Effectiveness submission, the Directed Payments were allocated only to the Traditional TANF and ACA Adult MEGs.

The impact of the Directed Payment allocation revisions reduced the PMPM for Traditional TANF and increased the PMPMs for the other MEGs. The changes for P1 PMPMs are delineated below for illustration – note the total projection is virtually unchanged on a PMPM basis.

MEG	Original PMPM	Revised PMPM	Change PMPM
TANF Pregnant Women	$1,461.65	$1,692.08	$230.43
SSI 0 – 18 yrs	$574.56	$738.25	$163.69
SSI 19+ yrs	$1,002.15	$1,144.31	$142.16
TANF Title V CSHCN	$1,397.66	$1,410.49	$12.83
Traditional TANF	$363.55	$324.86	($38.69)
ACA Adult Expansion	$578.74	$580.44	$1.70
Total	$522.19	$521.94	($0.25)

The impact of the Directed Payment allocation revisions reduced the PMPM for Traditional TANF and increased the PMPMs for the other MEGs. The changes for P2 PMPMs are delineated below for illustration – note the total projection is virtually unchanged on a PMPM basis.

MEG	Original PMPM	Revised PMPM	Change PMPM
TANF Pregnant Women	$1,541.59	$1,859.09	$317.50
SSI 0 – 18 yrs	$603.00	$821.74	$218.74
SSI 19+ yrs	$1,052.29	$1,242.29	$190.00
TANF Title V CSHCN	$1,473.69	$1,490.58	$16.89
Traditional TANF	$400.59	$350.59	($50.00)
ACA Adult Expansion	$637.86	$638.57	$0.71
Total	$569.72	$569.35	($0.36)

The Directed Payment allocation revisions for P1 and P2 are reflected on Tabs D5, D6, and D7.

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

E.___ Other (please describe):

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

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., 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 actual trend rate used is: 2% annually. Please document how that trend was calculated:

Trend Months R1 to P1 = 18, P1 to P2 = 12, Annual Trend % = 2%

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.
R1 was selected as our base period. While R2 is a more recent look at program experience, it only contains 6 months of experience - thus, is subject to additional volatility and seasonality versus using a 12-month period. Therefore, we have used R1 as it represents a complete 12 month period and is a more appropriate baseline off which to base our projections. The number of trend months in our projection (trending midpoint to midpoint from base to projection period)

R1 to P1: 24 months P1 to P2: 12 months

State Plan Trend, State Plan programmatic changes, and admin cost adjustment all

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

MHT and MHP will have two separate Workbooks submissions

- Cost Effectiveness Evaluation Workbook – to evaluate R1 and R2 amounts to prior waiver approval P1 and P2 amounts
- Waiver Renewal Projection Workbook – to establish SFY22 and SFY23 P1 and P2 amounts

The two separate Workbook submissions will

- help bring the state in alignment with the Cost Effectiveness instructions (e.g. using paid vs. incurred data)
- include Waiver and Non-Waiver costs into projection amounts.
- going forward bring the state into alignment with the prescribed measurement periods (R1 – R2, P1 – P2)
- provide a more accurate comparative cost effectiveness analysis of R1 and R2 amounts to Current Waiver P1 and P2 amounts
- provide an actuarially sound base year time period (full 12 months) for the development of the SFY22 – SFY23 Waiver Renewal P1 and P2 amounts

Please see below graphic illustrating the different workbooks and associated time periods.

West Virginia 1915b Waiver Renewal and Cost Effective Analysis Time Periods

	TWO COST EFFECTIVE WORKBOOKS PER WAIVER (FOUR TOTAL)											
	CURRENT WAIVER DATES		EVALUATION				PROJECTION					
			R1		R2		Base Period (12 months)		P1		P2	
	Start	End	Start	End	Start	End	Start	End	Start	End	Start	End
MHT	10/1/2019	6/30/2021	10/1/2019	6/30/2020	7/1/2020	12/31/2020	7/1/2019	6/30/2020	7/1/2021	6/30/2022	7/1/2022	6/30/2023
MHP	2/1/2020	6/30/2021	2/1/2020	6/30/2020	7/1/2020	12/31/2020	1/1/2020	12/31/2020	7/1/2021	6/30/2022	7/1/2022	6/30/2023

Note Waiver Start dates for both MHT and MHP do not coincide with beginning of State Fiscal Year.

MHP was not actually operationalized until March 1, 2020.

R1 will be submitted to match P1 for current waiver.

MHP expenditures will begin with March, 1, 2020

R2 will be submitted to match P2 for current waiver **using available data thru December 31, 2020.**

The projection base periods have been adjusted to include twelve months of actual data. The twelve months of data help account for seasonality and provide a comparable period for P1 and P2 estimates.

R1 to R2: R2 only represents a 6-month time period and is not credible for review as exhibited by the unreasonable trends being calculated.

R2 to P1: R2 only represents a 6-month time period and is not credible for review as exhibited by the unreasonable trends being calculated. In addition to the 11.3% trend (5.5% annually) that is being applied for 24 months from R1 per the CBO, there will be an additional 3.9% in costs related to program changes and an additional $0.91 PMPM for administrative expenditure growth.

P1 to P2: the annualized increase of 5.5% ties back to the CBO trend of 5.5%.

R2 to P1: National or regional 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.