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

MMA Amendment Version
July 18, 2005

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Instructions – see Attachment 1

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

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of _Nevada_ _____ 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 _Dental Benefits Administrator (DBA) _____. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ initial request for new waiver. All sections are filled.

_X__ amendment request for existing waiver, which modifies Section/Part

- Section A, Part I: Program Description: Program Overview.
- Section A, Part I(A)(2)(d): Program Description: Program Overview: Statutory Authority; Sections Waived: Section 1902(a)(4).
- Section A, Part I (1): Program Description: Program Overview, Populations Included in Waiver: Included Populations.
- Section A, Part IV (C)(1): Program Description, Program Operations, Enrollment and Disenrollment, Assurance.
- Section A, Part IV (C)(2)(d): Program Description: Program Operations: Enrollment and Disenrollment: Details: Disenrollment.
- Section D: Cost Effectiveness: D5 of the worksheet.

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

__ Document is replaced in full, with changes highlighted

___ renewal request

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

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

Section A is ___ replaced in full

_X__ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_X_ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

_X__ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

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

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective _7/01/2026_____and ending _03/31/2028_____. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Jimmy Lau, Esq., Deputy Administrator and can be reached by telephone at (775) 315-0043, or e-mail at _jlau@nvha.nv.gov_. (Please list for each program)

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.

A tribal letter was sent to the Inter-Tribal Council of Nevada on May 15, 2026, notifying the tribes of the intent to amend the 1915(b)(4) Dental Prepaid Ambulatory Health Plan (PAHP) Waiver. The tribal governments did not request a consultation.

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 1915(b) Waiver authorizes a Prepaid Ambulatory Health Plan (PAHP), referred to as the Dental Benefits Administrator (DBA), to administer and deliver dental services to Medicaid members residing in urban Clark and urban Washoe Counties within Nevada. Contracting with a DBA is intended to strengthen Nevada's Medicaid dental program by emphasizing preventive care, early intervention, improving continuity of care through integrated dental, medical, behavioral and social care; ensuring each member has access to a dental home; expanding quality provider network access; monitoring and encouraging appropriate dental utilization through dental disease prevention, outreach, and education initiatives; and effectively monitoring program integrity activities.

Nevada's contracted DBA began providing services for members on January 1, 2018, after receiving a score of 92.7% in the Readiness Review performed by the External Quality Review Organization (EQRO) vendor for the Nevada Health Authority, Nevada Medicaid (previously the Division of Health Care Financing and Policy (DHCFP)). During its time in operation, the DBA has conducted and/or participated in 1000+ community outreach events, enrolled each member in a dental home, and maintained a network of general dental providers that exceeds the standards set forth in the contract with the State. Nevada has seen an increase in adult utilization of Medicaid-covered services that is correlated to the DBA's value-added benefit of dental cleaning for adults. During the COVID-19 statewide shutdown, the DBA experienced a decrease in service numbers which have since returned to pre-pandemic levels. Starting March 18, 2020, the DBA began offering tele-dentistry services to its members and, as a value-added service, made these services available statewide from March 18, 2020, to June 30, 2020.

During the current waiver period, the DBA continued its outreach efforts and participated in pilot projects that seek to improve the dental health of all enrollees. These pilot projects include a value-based payment program, a vital pulp therapy program, fluoride application

through tele-dental visits, and a health behavior reward program for enrollees ages 0-20 who have not seen a dentist in the past 12 months.

In the upcoming waiver period, the DBA will continue its outreach efforts and participate in pilot projects that seek to improve the dental health of all members. The DBA will expand their adult dental services and participate in the 1115 demonstration waiver – Whole Mouth Whole Body Connection for Adults with Diabetes. The effective date of the expansion of adult dental services is July 1, 2026, was approved by CMS on May 14, 2026.

The DBA will continue value-added initiatives. Key efforts include: the Behaviors Incentive Program, Brush-Child program, and the Adult Brush Select Program. The DBA will expand community engagement through regular MCO and community event participation, and ongoing Oral health Risk Assessment (OHRA) completion. School-based programs will transition to direct service delivery, including caries risk assessments and fluoride applications with increased frequencies. Additional initiatives include targeted outreach to pregnant members and continuation of Performance Improvement Projects (PIP) focused on transportation coordination, pediatric preventive care, and rapid-cycle improvements across member populations.

A. Statutory Authority

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

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

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

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

d. _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

___ MCO
___ PIHP
_X_ 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. _X__ **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. _X__ **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).

The State seeks waiver of 42 CFR 438.56(c)(2)(i)-(iii) as described in Section A (Program Description) Part IV (Program Operations) C (Enrollment and Disenrollment).

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

B. Delivery Systems

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

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

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

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

c._X__ **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.

_X__ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

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

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

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

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

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

___ 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.

_X__ 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.

Members enrolled with the DBA are given freedom of choice in selecting a dental provider/dental home within the DBA's network. The DBA is also required to maintain and report on network adequacy/accessibility, including quarterly geo-access mapping and data-driven analysis.

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

___ 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.
_X__ Other: (please describe)
The DBA is currently designed as a single PAHP provider for urban Clark and urban Washoe counties. Members will maintain freedom of choice in selecting a dental provider/dental home within the DBA's network.

3. **Rural Exception.**

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

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

_X__ Beneficiaries will be limited to a single provider in their service

area (please define service area).
The DBA is currently designed as a single PAHP provider for urban Clark and urban Washoe counties. Beneficiaries will maintain freedom of choice in selecting dental providers/dental homes within the DBA's network.

___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

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

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

_X__ **Less than Statewide**
Limited to the urban Clark and urban Washoe counties by zip code.

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)
Clark County (urban)	PAHP	LIBERTY Dental Plan
Washoe County (urban)	PAHP	LIBERTY Dental Plan

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

_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

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

X **American Indians and Alaskan Natives** who are members of federally recognized tribes except when the MCO is in the Indian Health Services (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with IHS.

____ Mandatory enrollment
_X_ Voluntary enrollment

_X_ **Children With Special Health Care Needs (CSHCN)** are children under the age of 19 who are receiving services through a family-centered, community based, coordinated care system that receives grant fund under section 501(a)(1)(D) of Title V, and are defined by the state in terms of either program participation or special health care needs.

____ Mandatory enrollment
_X_ Voluntary enrollment

X_ **TANF and CHAP Adults Diagnosed as Seriously Mentally Ill (SMI)**

X_ Mandatory enrollment
__ Voluntary enrollment

_X_ **TANF and CHAP Children Diagnosed as Severely Emotionally Disturbed (SED)**

____ Mandatory enrollment
_X_ Voluntary enrollment

_**X**__**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.

_X__ Mandatory enrollment
___ Voluntary enrollment

_X_ **Other:** Eligible American Indians and Alaskan Natives who are eligible as Nevada Medicaid or Nevada Check Up recipients may choose to opt out of enrollment in the DBA.

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.

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

_X__ **Other** (Please define):

1. Qualified Medicare Beneficiaries (QMB) who are not covered under full Medicaid benefits.
2. Specified Low Income Medicare Beneficiaries (SLMB).
3. Qualified Individuals (QI) Medicare beneficiaries with income between 120 percent and 135 percent of the federal poverty level. States pay the Part B premiums for these individuals, and they are not eligible for full Medicaid benefits.
4. Qualified Disabled Working Individuals (QDWI).
5. Undocumented aliens including non-qualified, undocumented and qualified aliens, who have not met the five-year bar, are eligible for care and services related to the treatment of an approved emergency medical condition.

F. Services

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

1. **Assurances.**

_X__ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

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

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

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

_X__ The state assures CMS that it complies with Title I of the 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:

___ 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):

_X__ Family planning services are not included under the waiver.

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

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
___ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to

FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

_X_ 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.**

___ 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:

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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 number of PCCM PCPs with **open panels**. Please describe the State's standard.

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

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.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

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

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.

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

Statewide Average: (e.g. 1:500 and 1:1,000)	

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. _X_ 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.
This PAHP covers dental services only. In accordance with 42 CFR 438.208(a)(2), the State has determined that the implementation of a mechanism for identifying, assessing and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of 42 CFR 438.208, is not applicable given the limited scope of the program.

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 Nevada Health Authority Division of Medicaid has an Office of Analytics that can pull data based on diagnosis codes or procedure codes to identify persons with special health conditions.

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 DBA must develop and document a proposed course of treatment for Members with special health care needs who, based on an assessment conducted by appropriately qualified health care professionals, are determined to require ongoing treatment or regular care monitoring.

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 is receives **health education/promotion** information. Please explain.

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

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

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

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

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

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

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.

The vendor must furnish services in the same amount, duration and scope as services furnished to recipients under Fee-for-Service (FFS) Medicaid as set forth in 42 CFR 440.230. The vendor:

A. Must ensure the services are sufficient in amount, durations and scope to reasonably be expected to achieve the purpose for which the services are furnished.
B. May not arbitrarily deny or reduce the amount, duration, or scope of required service solely because of the diagnosis, type of illness, or condition of the recipient.
C. May place appropriate limits on a service based on criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and
D. Make prior authorization decisions within the timeframes described in Nevada Assembly Bill 463 and Nevada Revised Statute (NRS) 687B.225.

The vendor is responsible for covering services related to the prevention, diagnosis, and treatment of oral health impairments; supporting the achievement

of age-appropriate growth and development; and enabling members to attain, maintain, or regain functional capacity. Such services shall be provided in a manner no more restrictive than that applied under the State Medicaid and CHIP programs, as set forth in applicable State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policies and procedures, including the Medicaid Services Manual (MSM).

The vendor's role is to ensure the accessibility and availability of appropriate dental care promote continuity of care and deliver high-quality services to enrolled recipients. The Vendor shall maintain a customer service line to assist Members with locating providers, scheduling appointments, and addressing customer service needs related to care coordination. While Members are required to utilize one contracted vendor, they retain freedom of provider choice within the vendor's network, with the added benefit of care coordination services.

Section A: Program Description

Part III: Quality

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

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

___ The State seeks a waiver of 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.

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

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

___ 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				
PIHP				

2. **Assurances For PAHP program.**

_X__ 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.

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

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):

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):

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

The Nevada Medicaid Division of the Nevada Health Authority (NVHA) used the State's open competitive procurement process in selecting a vendor, which is required by the Nevada State Purchasing Department for all state purchases.

Quality and Performance Standards: The role of the vendor is to ensure accessibility and availability to appropriate dental care, provide for continuity of care and provide quality care to enrolled members. Members benefit from preventive dental care services, the quality and availability of which are monitored and evaluated by NVHA, Nevada Medicaid in conjunction with the NVHA, Nevada Medicaid's External Quality Review Organization (EQRO) contractor. The vendor is required to work collaboratively with NVHA, Nevada Medicaid and the EQRO in these quality monitoring and evaluation activities. The vendor is required to designate a lead person to work with NVHA, Nevada Medicaid on quality management. By virtue of the NVHA, Nevada Medicaid's contract with the EQRO and the federal regulations which set forth the State's mandates for an EQRO, the vendor has provided reporting data and has participated in additional EQRO activities as assigned and required by NVHA, Nevada Medicaid.

Provider Selection Process: A Request for Procurement (RFP) was issued on March 16, 2022, $40DHHS/S1834, by the Nevada State Purchasing Division and posted on their website at: https://purchasing.nv.gov/. The website is available to all interested bidders, regardless of location, by the internet. The criteria used for selection was evaluated and scored in accordance with Nevada Revised Statute (NRS) 333.335(3) based upon the following criteria:

Dental Provider Services – 250 points
Benefits and Services Delivery – 205 points
Network and Access to Care – 325 points
Reporting and Monitoring – 150 points
Clinical and Quality – 350 points
Business and Operations – 125 points
Note: Financial stability will be scored on a pass/fail basis.

Bid submissions were reviewed and scored independently by members of the appointed evaluation team and then through consensus scoring, each criterion was scored based on the points available and totaled, with the award to the highest scoring bidder.

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

1._X__The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers . The vendor is a single PAHP for members and therefore does not participate in marketing as it is defined in 42 CFR §438.104.

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

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

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

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

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

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

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

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

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

1._X_ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant." NVHA, Nevada Medicaid generates a report every two years as required by Nevada Revised Statute (NRS) 232.0081 of the number of people who have identified a language other than English as their preferred language. The target threshold for automatic translation to another language is 5% of the population or 1,000 members, whichever is fewer. When membership reaches this threshold of those who have identified another language as their preferred language, all materials that are vital to participation in the program should be automatically translated and distributed

in that preferred language. If the threshold drops after the document has been translated, NVHA, Nevada Medicaid maintains the document until it is outdated.

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3. _X_ Other (please explain):
The vendor must participate in state and federal efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The State has identified the prevalent non-English language in Nevada to be Spanish. 42 CFR §438.206(C)(2), and NVHA, Nevada Medicaid require that vendors offer accessible and high-quality services in a culturally competent manner. Per the contract, all materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's Members who also have Limited English Proficiency (LEP) in that language. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's Members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, and vital information from the member Handbook. All written notices informing Members of their right to interpretation and translation services must be translated into the appropriate language when the Contractor's caseload consists of 1,000 Members that speak that language and have LEP.

_X__ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.
The vendor notifies all members that free oral interpretation is available for any language. The "Nevada Medicaid Welcome Packet" provided to new members upon enrollment and information listed in the member handbook includes a description about the availability of oral interpretation for any language.

_X__ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.
Provision of informational materials is sent to members periodically. Members have access to customer service staff who can answer questions about the program materials

face-to-face and/or by telephone in a language the member can understand. The vendor is required to maintain a member services department that personally assists members in obtaining information and services under the vendor's plan.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

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

c. Enrollee Information

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

(i) ___ the State
(ii) ___ State contractor (please specify):_____
(ii) _X__ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

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.

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

The State seeks waiver of the provisions of 42 CFR 438.56(c)(2)(i)-iii). The State requires Mandatory enrollment for beneficiaries in urban Clark and urban Washoe counties to Nevada Medicaid's single contracted PAHP for dental services administered in accordance with the Nevada Medicaid State Plan. Therefore, the State seeks to waive the provisions of 42 CFR 438.56(c)(2)(i)-(iii) related to certain without cause disenrollments. The State is not seeking waiver of the provision of 42 CFR 438.56(c)(2)(iv) to preserve the ability for enrollees to request without cause disenrollment in the event the State imposes an intermediate sanction against the State's single contract PAHP pursuant to 42 CFR 438.702(a)(4). Beneficiaries will maintain freedom of choice in selecting a dental provider/dental home within the PAHP's network.

The State assures that the State's systems have the functional capacity to effectuate for members mandatorily assigned to the single PAHP a good cause disenrollment and without cause disenrollment pursuant to 42 CFR 438.56(C)(2)(iv). The State further assures that such disenrollments will occur without impacting the enrollee's enrollment status in any other form of managed care for which the enrollee may be presently enrolled.

_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.

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

b. **Administration of Enrollment Process**.

_X__ State staff conducts the enrollment process.

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

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

Broker name: _____

Please list the functions that the contractor will perform:

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

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

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

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

___ 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.):

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

i. ___ Potential enrollees will have____days/month(s) to choose a plan.

ii. ___ 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.

_X__ 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)

_X__ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

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

_X__ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
The State of Nevada exempts the following Medicaid recipient groups from mandatory enrollment, but gives the recipients the option of voluntarily enrolling in an MCO (and therefore, the PAHP) if they choose:

1. American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes except when the MCO is the Indian Health Service (IHS); or and Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS.
2. Children under the age of 19 years who are receiving services through a family centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs (known as Children with Special Health Care Needs – CSHCN);
3. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED).

___ 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.

d. **Disenrollment:**

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

i.___ Enrollee submits request to State.

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

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

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

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

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

_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:
The vendor may request disenrollment of a member if the continued enrollment of the member seriously impairs the vendor's ability to furnish services to either the particular member or other members. In addition, the vendor must

confirm the recipient has been referred to the vendor's Recipient Services Department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the issue. Prior approval by NVHA, Nevada Medicaid of a vendor's request for the member's disenrollment is required. Dental Service will then be furnished under FFS.

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

___ 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.

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

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

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

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

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

b. **Timeframes**

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

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

c. **Special Needs**

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

4. **<u>Optional grievance systems for PCCM and PAHP programs</u>**. 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.

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

_X__ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- _X__ the PAHP.

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

The DBA has established a grievance and appeal system for members and providers. The grievance system is used for any expression of dissatisfaction about a matter other than an adverse benefit determination, as defined in 42 CFR §438.400. Possible issues for grievances include, but are not limited to, access to care, quality of services, interpersonal relationships between DBA staff and members, and failure to respect a member's rights.

A provider acting on behalf of the member may file an appeal or grievance. The provider must first obtain the member's written permission.
The nature of an expression of dissatisfaction can be medical and/or non-medical.

___ 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.

_X__ Specifies a time frame from the date of action for the enrollee to file a request for review, which is:
at any time for a grievance and within 60-calendar days of the notice of Action for an appeal. (please specify for each type of request for review)

_X__ Has time frames for resolving requests for review. Specify the time period set:
The vendor is required to resolve each grievance and appeal as expeditiously as the member's health condition requires. The DBA is allowed no more than 90 calendar days from date of receipt to resolve a grievance and no more than 30 calendar days from the date of receipt to resolve an appeal. (please specify for each type of request for review)

_X__ Establishes and maintains an expedited review process for the following reasons: Specify the time frame set by the State for this process.
For cases in which a provider indicates or the vendor determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the DBA makes an expedited authorization decision and provides a Notice of Action as expeditiously as the member's health condition warrants and no later than 72 hours after receipt of the requester for service. The DBA may extend the 72-hour time period by up to 14 calendar days if the member requests and extension or if the vendor justifies (to NVHA, Nevada Medicaid up request) a need for additional information and how the extension is in the member's best interest. The DBA provides written notice of the reason for the extension and informs members of their right to file a grievance.

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

_X__ 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**

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

___ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

Section B: Monitoring Plan

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

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

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

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

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

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

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

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

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Member Content Review		X										
Secret Shopper Survey							X					

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)

___ NCQA
___ JCAHO
___ AAAHC
_X__ Other (please describe)

The contract requires the vendor to be accredited by a nationally recognized accrediting organization that conducts an independent assessment of the quality of care provided by the vendor.

1. The NVHA, Nevada Medicaid DBA Specialist is the personnel responsible.
2. The vendor is responsible for providing their accreditation certificate to NVHA, Nevada Medicaid.
3. The specialist will review the accreditation submission annually.
4. If the specialist does not receive the accreditation the specialist will follow up with the vendor. If further compliance issues are found, a corrective action plan will be assigned. If the vendor cannot pass

accreditation, the NVHA, Nevada Medicaid will begin the contract termination process.

c. _____ Consumer Self-Report data

___ CAHPS (please identify which one(s))
___ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

d. __ X___ Data Analysis (non-claims)

___ Denials of referral requests
___ Disenrollment requests by enrollee
___ From plan
___ From PCP within plan
_X__ Grievances and appeals data
___ PCP termination rates and reasons
_X__ Other (please describe)

1. Responsible personnel are NVHA, Nevada Medicaid Surveillance and Utilization Review Unit, NVHA, Nevada Medicaid Hearings Unit, and NVHA, Nevada Medicaid Managed Care Delivery Systems Unit (MCDS).
2. The DBA submits reports for the following areas: compliance, financial, (used to be program integrity), program monitoring related to network adequacy, clean claims, population health, member and provider satisfaction, grievances, and dispute resolution.
3. Reports and data are submitted to the state monthly, quarterly, annually, and on occurrence basis.
4. If analysis of reports and/or data indicates a program issue may exist, then the appropriate program specialist will notify the DBA and the MCQA program specialist for contractual compliance review.

e. _____ Enrollee Hotlines operated by State

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. __X___ Geographic mapping of provider network

1. The personnel responsible is the NVHA, Nevada Medicaid MCDS Reports Team.

2. The DBA vendor submits a monthly geo access mapping report to the State that provides an accessibility summary of general dentists and specialists within the network in relations to where the membership lives.
3. This report is submitted monthly and reviewed by the NVHA, Nevada Medicaid MCDS Management Analyst.
4. If the analysis of the report indicates a program issue may exist, then the MCDS Management Analyst follows up with the vendor related to contract compliance and necessary corrective actions.

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

i. _____ Measurement of any disparities by racial or ethnic groups

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

The DBA must maintain an adequate network that ensures the following:

1. The NVHA Nevada Medicaid DBA Specialist is responsible for receiving and analyzing if the DBA vendor is meeting network adequacy requirements as outlined within the contract.
2. The Vendor must have at least one (1) full-time equivalent (FTE) Dentist, considering all lines of business for that Provider, for every one-thousand five hundred (1,500) Members per service area. The Vendor must demonstrate that the capacity of the Primary Dental Provider (PDP) Network meets the FTE requirements for accepting eligible Members per service area. This ratio cannot exceed the FTE requirement. In no case may a single provider accept more Members than allowed by the FTE requirement.
3. On a quarterly basis, the vendor is required to use geo-access mapping and data-driven analyses to ensure compliance with access standards and take appropriate corrective action, if necessary. The vendor also submits quarterly network adequacy reports and monthly provider count reports to NVHA, Nevada Medicaid for review.
4. The geo-access map allows the NVHA, Nevada Medicaid specialist to ensure the required time and distance standards are met. Additionally, the Network Adequacy Reports allow the specialist to identify the provider to member ratios are contractually compliant. If reports indicate a program issue may exist, then the NVHA, Nevada Medicaid DBA Specialist is responsible for following up with the DBA related to non-compliance issues and possible corrective actions.

k. _____ Ombudsman

l. __X___ On-site review

1. The State contracts with an External Quality Review Organization (EQRO) vendor that conducts an annual compliance review of the DBA. Due to the changing practices related to the COVID-19 pandemic and in line with the updated EQRO protocols, site visits may be conducted onsite or virtually.
2. The compliance review is conducted in line with the EQRO protocols. NVHA, Nevada Medicaid and the contracted EQRO review specific standards as outlined within the protocol during each year of the three (3)-year review period. The first seven (7) standards are reviewed in year one (1). The remaining seven (7) standards are reviewed in year two (2). In year three (3), a comprehensive review is conducted on each element that is determined *not met* during years one (1) and two (2). The elements under review for specific years are outlined within the EQR Technical Report. Findings of the reviews are reported annually.
3. The compliance review allows the EQRO and NVHA, Nevada Medicaid to ensure that the policies and practices that have been authorized by NVHA, Nevada Medicaid are in utilization and supported by records review for each standard that is reviewed. If the vendor has findings from the compliance review, then the NVHA, Nevada Medicaid DBA Specialist and EQRO vendor work with the DBA vendor to establish corrective action plans to resolve the issues and bring the vendor back into compliance.

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

_X__ Clinical

For State Fiscal Year (SFY) 2024-2025, LIBERTY Dental conducted one clinical PIP.

1. Preventive Services for Children: To improve the percentage of children receiving preventive services who are between 0 to 20 years of age.

   Aim: Do targeted interventions to increase the percentage of eligible enrollees 0 to 20 years of age that had any topical fluoride or sealants during the measurement year.

   Intervention Description: Multiple program text campaigns aimed to reach targeted member population and increase utilization of preventive dental services.

   Intervention Impact: The PAHP reported the intervention was effective for improving the percentage of children receiving preventive services. The PAHP reported for the baseline that 40.09% of children received a topical fluoride applications and/or sealant. The PAHP reported an increase to 44.22%, an improvement of 4.13% compared to the baseline rate.

Intervention Status: The PAHP will continue to stratify measurement data and address any disparities in future measurement periods. The PAHP has developed interventions to increase awareness and education to increase utilization, as well as to engage providers in this effort.

_X_ Non-clinical

For State Fiscal Year (SFY) 2024-2025, LIBERTY Dental conducted one non-clinical PIP.

1. Coordination of Transportation Services: Overall improvement of coordination of transportation services between the plan and members.
   Aim: Targeted interventions to increase the success rate of transportation coordination between the plan and the transportation vendor for members to and/or from covered oral health services. Targeted interventions to increase the percentage of successful requests for transportation to and/or from covered oral health services that LIBERTY referred to and/or scheduled with the plan's transportation vendor.
   Intervention Description: The PAHP conducted continued outreach to non-utilizing members to educate the availability as well as appointment coordination of transportation. Conduct monthly outreach campaigns offering information and assistance with transportation services.
   Intervention Impact: The PAHP reported intervention was ineffective and performance indicator results did not demonstrate statistically significant improvement at the first remeasurement and instead declined below the baseline. The PAHP reported for the baseline 45.9% of requests for transportation to and/or from covered oral health services that the PAHP referred to and/or scheduled with NVHA, Nevada Medicaid's contracted transportation vendor. The PAHP reported a decline by 6.7% compared to the baseline rate
   Intervention Status: The PAHP will continue outreach to all transportation requests to encourage utilization of transportation services.

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

Process
Health status/outcomes
Access/availability of care

The NCQA has retired both the ADV measure and the PDENT measure. New measures Oral Evaluation, Dental Services (OEV), Sealant Receipt on Permanent First Molars (SFM), and Topical Fluoride for Children (TFL).

Performance measure results for Federal Fiscal Year (FFY) 2024.

Table C-1—Medicaid FFY 2024 Performance Measure Results for LIBERTY

Performance Measures	MY 2023 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
Ages <1	1.49%
Ages 1–2	20.73%
Ages 3–5	41.19%
Ages 6–7	50.25%
Ages 8–9	51.24%
Ages 10–11	50.43%
Ages 12–14	46.47%
Ages 15–18	38.19%
Ages 19–20	22.41%
Total (Ages <1–20)	39.75%
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	56.69%
Rate 2—All Four Molars	38.30%
Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—Ages 1–2	5.96%
Rate 1—Dental or Oral Health Services—Ages 3–5	18.44%
Rate 1—Dental or Oral Health Services—Ages 6–7	23.36%
Rate 1—Dental or Oral Health Services—Ages 8–9	24.38%
Rate 1—Dental or Oral Health Services—Ages 10–11	23.71%
Rate 1—Dental or Oral Health Services—Ages 12–14	19.93%
Rate 1—Dental or Oral Health Services—Ages 15–18	13.69%
Rate 1—Dental or Oral Health Services—Ages 19–20	4.99%
Rate 1—Dental or Oral Health Services—Total (Ages 1–20)	17.30%
Rate 2—Dental Services—Ages 1–2	5.95%
Rate 2—Dental Services—Ages 3–5	18.28%
Rate 2—Dental Services—Ages 6–7	22.66%
Rate 2—Dental Services—Ages 8–9	23.76%
Rate 2—Dental Services—Ages 10–11	23.31%
Rate 2—Dental Services—Ages 12–14	19.88%
Rate 2—Dental Services—Ages 15–18	13.68%
Rate 2—Dental Services—Ages 19–20	4.99%
Rate 2—Dental Services—Total (Ages 1–20)	17.08%
Rate 3—Oral Health Services—Ages 1–2	0.0%
Rate 3—Oral Health Services—Ages 3–5	0.02%
Rate 3—Oral Health Services—Ages 6–7	0.06%
Rate 3—Oral Health Services—Ages 8–9	0.08%
Rate 3—Oral Health Services—Ages 10–11	0.04%
Rate 3—Oral Health Services—Ages 12–14	0.00%
Rate 3—Oral Health Services—Ages 15–18	0.00%
Rate 3—Oral Health Services—Ages 19–20	0.00%
Rate 3—Oral Health Services—Total (Ages 1–20)	0.02%

Performance measure results for Nevada Check Up FFY 2024

Table C-2—Nevada Check Up FFY 2024 Performance Measure Results for LIBERTY

Performance Measure	MY 2023 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
Ages <1	2.38%
Ages 1–2	24.81%
Ages 3–5	48.89%
Ages 6–7	59.53%
Ages 8–9	59.39%
Ages 10–11	59.07%
Ages 12–14	54.88%
Ages 15–18	45.81%
Ages 19–20	25.22%
Total (Ages <1–20)	51.30%
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	60.64%
Rate 2—All Four Molars	40.75%

Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—Ages 1–2	9.04%
Rate 1—Dental or Oral Health Services—Ages 3–5	24.49%
Rate 1—Dental or Oral Health Services—Ages 6–7	31.41%
Rate 1—Dental or Oral Health Services—Ages 8–9	33.05%
Rate 1—Dental or Oral Health Services—Ages 10–11	32.43%
Rate 1—Dental or Oral Health Services—Ages 12–14	26.96%
Rate 1—Dental or Oral Health Services—Ages 15–18	19.87%
Rate 1—Dental or Oral Health Services—Ages 19–20	4.84%
Rate 1—Dental or Oral Health Services—Total (Ages 1–20)	25.88%
Rate 2—Dental Services—Ages 1–2	9.04%
Rate 2—Dental Services—Ages 3–5	24.22%
Rate 2—Dental Services—Ages 6–7	30.90%
Rate 2—Dental Services—Ages 8–9	32.30%
Rate 2—Dental Services—Ages 10–11	32.10%
Rate 2—Dental Services—Ages 12–14	26.94%
Rate 2—Dental Services—Ages 15–18	19.87%
Rate 2—Dental Services—Ages 19–20	4.84%
Rate 2—Dental Services—Total (Ages 1–20)	25.64%
Rate 3—Oral Health Services—Ages 1–2	0.00%
Rate 3—Oral Health Services- Ages 3–5	0.04%
Rate 3—Oral Health Services—Ages 6–7	0.03%
Rate 3—Oral Health Services—Ages 8–9	0.09%
Rate 3—Oral Health Services—Ages 10–11	0.00%
Rate 3—Oral Health Services—Ages 12–14	0.00%
Rate 3—Oral Health Services—Ages 15–18	0.00%
Rate 3—Oral Health Services—Ages 19–20	0.00%
Rate 3—Oral Health Services—Total (Ages 1–20)	0.02%

Performance measure results for FFY 2025.

Performance Measure	MY 2024 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
<3 Years	20.86%
3–5 Years	45.84%
6–14 Years	53.95%
15–20 Years	38.14%
Total (<21 Years)	44.17%
Total—Sex—Male	43.08%
Total—Sex—Female	45.29%
Total—Sex—Missing or Not Reported	NA*
Total–Geography—Rural	20.66%
Total–Geography—Urban	44.18%
Total–Geography—Missing or Not Reported	NA*
Total–Race—American Indian or Alaska Native	43.88%
Total—Race—Asian	52.87%
Total—Race—Black or African American	40.80%
Total—Race—Native Hawaiian or Other Pacific Islander	43.28%
Total—Race—White	50.76%
Total—Race—Two or More Races	51.16%
Total—Race—Some Other Race	44.96%
Total—Race—Missing or Not Reported	34.01%
Total—Ethnicity—Not Hispanic or Latino	43.41%
Total—Ethnicity—Hispanic or Latino	52.90%
Total—Ethnicity—Missing or Not Reported	36.86%

Performance Measure	MY 2024 Rate
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	60.65%
Rate 2—All Four Molars	41.97%
Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—1–2 Years	8.46%
Rate 1—Dental or Oral Health Services—3–5 Years	21.30%
Rate 1—Dental or Oral Health Services—6–14 Years	25.65%
Rate 1—Dental or Oral Health Services—15–20 Years	13.68%
Rate 1—Dental or Oral Health Services—Total (1–20 Years)	20.01%
Rate 2—Dental Services—1–2 Years	8.46%
Rate 2—Dental Services—3–5 Years	21.11%
Rate 2—Dental Services—6–14 Years	25.10%
Rate 2—Dental Services—15–20 Years	13.66%
Rate 2—Dental Services—Total (1–20 Years)	19.71%
Rate 3—Oral Health Services—1–2 Years	0.00%
Rate 3—Oral Health Services—3–5 Years	0.01%
Rate 3—Oral Health Services—6–14 Years	0.04%
Rate 3—Oral Health Services—15–20 Years	0.01%
Rate 3—Oral Health Services—Total (1–20 Years)	0.02%

Performance measure results for Nevada Check Up FFY 2025

Table C-2—Nevada Check Up FFY 2025 Performance Measure Results for LIBERTY

Performance Measure	MY 2024 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
<3 Years	28.33%
3–5 Years	47.05%
6–14 Years	59.31%
15–20 Years	47.02%
Total (<21 Years)	53.11%
Total—Sex—Male	51.90%
Total—Sex—Female	54.37%
Total—Sex—Missing or Not Reported	NA*
Total—Geography—Rural	NA*
Total—Geography—Urban	53.11%
Total—Geography—Missing or Not Reported	NA*
Total—Race—American Indian or Alaska Native	53.05%
Total—Race—Asian	52.17%
Total—Race—Black or African American	47.01%
Total—Race—Native Hawaiian or Other Pacific Islander	46.97%
Total—Race—White	62.36%
Total—Race—Two or More Races	57.33%
Total—Race—Some Other Race	52.77%
Total—Race—Missing or Not Reported	42.19%
Total-Ethnicity—Not Hispanic or Latino	50.77%
Total—Ethnicity—Hispanic or Latino	64.85%
Total—Ethnicity—Missing or Not Reported	44.37%
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	66.52%
Rate 2—All Four Molars	46.73%
Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—1–2 Years	12.44%
Rate 1—Dental or Oral Health Services—3–5 Years	25.09%
Rate 1—Dental or Oral Health Services—6–14 Years	32.98%
Rate 1—Dental or Oral Health Services—15–20 Years	20.59%
Rate 1—Dental or Oral Health Services—Total (1–20 Years)	27.83%
Rate 2—Dental Services—1–2 Years	12.44%
Rate 2—Dental Services—3–5 Years	24.85%
Rate 2—Dental Services—6–14 Years	32.38%
Rate 2—Dental Services—15–20 Years	20.53%
Rate 2—Dental Services—Total (1–20 Years)	27.44%
Rate 3—Oral Health Services—1–2 Years	0.00%
Rate 3—Oral Health Services—3–5 Years	0.00%
Rate 3—Oral Health Services—6–14 Years	0.03%
Rate 3—Oral Health Services—15–20 Years	0.01%
Rate 3—Oral Health Services—Total (1–20 Years)	0.02%

*NA—Measure rates that result in an NA are considered reportable; however, the denominator is too small to report (e.g., less than 30).

LIBERTY demonstrated consistent performance for the new measures OEV, SFM, and TFL. Overall, most rates for both populations have shown a steady increase, indicating LIBERTY's strategies to increase the prevalence of dental services amongst its members are effective.

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

o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ____ Provider Self-report data
___ Survey of providers
___ Focus groups

r. _____ Test 24 hours/7 days a week PCP availability

s. _____ Utilization review (e.g. ER, non-authorized specialist requests)

t. __X___ Other: (please describe)

1. Member Content Review:
   a. The responsible party is the NVHA, Nevada Medicaid DBA Specialist.
   b. The vendor is the singular dental PAHP provider and therefore does not submit marketing materials as it is defined in 42 CFR §438.104. The vendor does submit initial mass letter mailings and brochures or any subsequent change in content for members to the state for review and approval prior to release.
   c. The DBA Specialist will review member content materials and approve materials that meet federal and state requirements.

2. Secret Shopper Survey:
   a. The responsible party is the NVHA, Nevada Medicaid DBA Specialist.
   b. The vendor is required to conduct a secret shopper survey annually to verify appointment wait times are with acceptable limits.
   c. Annually, the DBA vendor will submit its Secret Shopper findings.
   d. If the NVHA, Nevada Medicaid DBA Specialist identifies timely access issues in the submission, then the specialist is responsible for following up with the vendor to ensure that quality improvement plans have been put in place. If it is determined that

the plan did not elect to make improvements as a result of the secret shopper, then the NVHA, Nevada Medicaid DBA Specialist will follow up on contract non-compliance issues and address them with a corrective action plan.

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:

Strategy: *b. Accreditation for Participation*
Confirmation it was conducted as described:

_X__ Yes

___ No. Please explain:
Summary of results: The DBA is accredited by URAC® - Dental Plan, 7.4 Accreditation Program as a Medicaid, Health Maintenance Organization, Nevada and Medicaid Exclusive Provider Organization, Nevada. The DBA provided a certificate of award as well as a summary of the accreditation results to the NVHA, Nevada Medicaid. NVHA, Nevada Medicaid dental program specialist reviewed the report which included a URAC® committee determination of "Full Accreditation" and an achievement score of 99.07%. All core requirements were met. The accreditation is effective from October 1, 2025 to July 1, 2028.

The DBA is also accredited by the National Committee for Quality Assurance (NCQA) Accreditation in Utilization Management as well as Credentialing and Recredentialing. The DBA provided certificates of award for demonstrating compliance with NCQA's requirements in both areas. The NCQA Accreditation is effective March 10, 2025 to March 10, 2028.

Problems identified: None
Corrective action (plan/provider level) None
Program change (system-wide level) None

Strategy: *d. Data Analysis (non-claims)*
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of results: NVHA, Nevada Medicaid conducted data analysis by using reports provided by the Managed Care Entities (MCE's) to collect grievance and appeal data. These reports provide the reason for the grievances, how many grievances were resolved, how many were pending, and the number of grievances that were expedited. For plan year 2024, A total of 653 grievances were resolved by the DBA. A total of 299 appeals were resolved by the DBA.

Problems identified: None
Corrective action (plan/provider level) No corrective action was issued. The DBA provided data to verify they are tracking grievances and appeals.
Program change (system-wide level) N/A

Strategy: *g. Geographic mapping of provider network*
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of results: The DBA met the Network Standards identified in the Contract. The DBA continues to add providers within all specialties throughout the year.
Problems identified: None
Corrective action (plan/provider level) No corrective action plan issued.

Program change (system-wide level) None

Strategy: *j. Network Adequacy Assurance by Plan*
Confirmation it was conducted as described:
__X__ Yes
___ No. Please explain:
Summary of results: The Network Adequacy Validation (NAV) activity for SFY 2025 involved analyzing network capacity and geographic distribution after the PAHP identified provider categories using a provider crosswalk developed by Nevada Medicaid's EQRO vendor in collaboration with NVHA, Nevada Medicaid during SFY 2019. This crosswalk ensured consistent classification of all ordering, referring, and servicing providers for the PAHP.
To assess the capacity of the PAHP's provider network, Nevada Medicaid's EQRO vendor calculated the provider-to-member ratio by comparing the number of providers in each category (e.g. general dentists, endodontists) to the number of members. This ratio services as a key metric for evaluating the overall capacity of the network to deliver services. A higher ratio suggests better access to services, as more providers are available for the same number of members. It is important to note that distinct provider counts were used, rather than counting provider locations.

Problems identified: None
Corrective action (plan/provider level) None
Program change (system-wide level) None

Strategy: *l. On-site review*
Confirmation it was conducted as described:
__X__ Yes
___ No. Please explain:
Summary of results: During the compliance review with the EQRO, the PAHP did not meet 20 elements. All 20 were corrected during the review period.

Problems identified: The following problems were identified:
Standard X (10), Grievance and Appeal systems, appeals, general requirements, handling of appeals, state fair hearings.

After the DBA/PAHP worked with the EQRO through each finding, the EQRO determined opportunities for improvement were identified in the areas of Grievance and Appeal Systems.

Corrective action (plan/provider level) The DBA/PAHP submitted a CAP to the EQRO and NVHA, Nevada Medicaid. Review determined the DBA's CAP was sufficient to ensure compliance. No additional information is required.

Program change (system-wide level) None

Strategy: *t. Other: Member Content Review*
Confirmation it was conducted as described:

_X__ Yes
___ No. Please explain:

Summary of results: The DBA is the singular dental PAHP provider and therefore does not submit marketing materials as it is defined in 42 CFR §438.104. However, the DBA submitted general communications and outreach material such as brochures, flyers for special events, member forms, scripts for text messages, and general communications to members for review and approval to the dental program specialist as documented by email correspondence. In addition to reviewing the content of material, the dental program specialist checked documents for readability at the sixth grade reading level as required by the contract.

Problems identified: None
Corrective action (plan/provider level) None
Program change (system-wide level) None

Strategy: *t. Other: Secret Shopper Survey*
Confirmation it was conducted as described:

_X__ Yes
___ No. Please explain:

Summary of results: To ensure appropriate access and availability standards are met and to identify opportunities for process improvements, the DBA's member services department conducted secret shopper surveys and provided activity report summaries to NVHA, Nevada Medicaid 90 days after Calendar Year end date in compliance with the Contract. For the most recent report, the DBA analyzed access and availability data for emergency services, urgent care, diagnostic care, preventive care, routine care, specialist emergency service, specialist urgent care, specialist routine care, adolescent specialist care. The DBA attempted to contact 286 offices. Six (6) offices could not be reached. The DBA found that 11 offices did not meet established standards. NVHA, Nevada Medicaid's dental program specialist reviewed the summary report and determined that quality improvements were initiated by the DBA network manager who contacted all 11 offices to provide counseling and will monitor future compliance. (From outreach efforts, it was noted that reduced hours and days of operation due to staff shortages was the main reason for offices being unreachable).

Problems identified: Eleven (11) offices did not meet established standards.
Corrective action (plan/provider level) The DBA network manager contacted all 11 offices, provided counseling, and will monitor future compliance.
Program change (system-wide level) None

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: __Lynnette Aaron_____

c. Telephone Number:__(775) 684-3639__

d. E-mail:__l.aaron@nvha.nv.gov_____

e. The State is choosing to report waiver expenditures based 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 Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

b.___ The State makes enhanced payments to contractors or providers.

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

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

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

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

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

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

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

a.___ MCO
b.___ PIHP
c._X__PAHP
d.___ Other (please explain):

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

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

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

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

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

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

_____

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

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

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

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

_____

For Conversion or Renewal Waivers:

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

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

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: Projections take into account historical data, economic conditions, and population growth. Stabilizing economic factors and the predicted effect of HR 1 are leading to the decrease in member months in the projections.

_____

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

e.__X_[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: R1 reflects October 1, 2023 through September 30, 2024. R2 reflects October 1, 2024 through September 30, 2025.

_____.

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**: No different services.

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: No excluded services.

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
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*

documentation for justification of savings.)			
N/A	N/A	N/A	N/A
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

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

b._X__ 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.*
Administrative costs are allocated based upon the program cost as a percentage of the total service costs. For each MEG, the actual dental costs for MCO dental waiver clients is divided by the medical costs for that MEG to determine the ratio to apply to the administrative costs.

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
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
N/A	N/A	N/A	N/A
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*

care. See attached documentation for justification of savings.)	*$1.04 PMPM R2 or BY in Conversion*		
N/A	N/A	N/A	N/A
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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

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

Basis and Method:

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

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

d.___Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

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

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

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

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

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This

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

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: 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 to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

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

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

Method:

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

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

Basis and method:

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

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

Basis and Method:

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

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

   1.___ We assure CMS that DSH payments are excluded from base year data.
   2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
   3.___ Other (please describe):

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

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

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

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

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.___ Other (please describe):

Special Note section:

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

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

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

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to

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

Adjustment	**Capitated Program**	**PCCM Program**
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.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2._X__[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated 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. _X_ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used the medical care services inflation rate prediction for FFY 26 4.36% and FFY 27 3.49% from Moody's Analytics were used to increase the PMPM and administrative portions of the calculation.
In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver

separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

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

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

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

Others:

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

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS

claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

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

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

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

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

E. X Other (please describe): In the 83rd Regular Session of the Nevada Legislature approved adding adult dental services totaling $8,485,717 for State Fiscal Year (SFY) 2026, consisting of $6,829,986 of federal funds, $1,632,313 of state general funds, and $23,418 of county funds. Totaling $8,612,139 for SFY 2027, consisting of $6,924,379 of federal funds, $1,663,169 of state general funds, and $24,591 of county funds.

The adjustment for these services is not currently included in the Per Member Per Month (PMPM) calculations. The exact amount of the midyear rate adjustment is not yet determined. Following the midyear rate adjustment, the state will make payments to the dental benefits administrator to align with the revised capitation rate and seek to submit an amendment to account for the rate change.

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

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

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

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

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

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

D.____ Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ Other (please describe):

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

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

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.___ Cost increases were accounted for.

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

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

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. _X___ Other (please describe): The medical care services inflation rate prediction for FFY26 is 4.36% and FFY 27 is 3.49% from Moody's Analytics were used to increase the PMPM and administrative portions of the calculation.

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):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

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

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. The medical care services inflation rate prediction for FFY26 is 4.36% and FFY 27 is 3.49% from Moody's Analytics were used to increase the PMPM and administrative portions of the calculation.

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**: Projections take into account historical data, economic conditions, and population growth. Stabilizing economic factors and the predicted effect of HR 1 are leading to the decrease in member months in the projections.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**: Projections take into account historical data, economic conditions, and population growth. Stabilizing economic factors and the predicted effect of HR 1 are leading to the decrease in member months in the projections.

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 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.

Attachment 1

Instructions for

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

July 18, 2005
MMA amendment version

Draft

Preprint Instructions

Introduction

This waiver preprint is for a State's use in requesting authority under section 1915(b) of the Social Security Act (the Act) to operate a managed care program. Specifically, it is designed for use in authorizing programs involving Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) systems. In addition, it can be used for section 1915(b)(4) fee-for-service selective contracting programs. Use of this 1915(b) waiver preprint is strongly encouraged.

Section 1915(b) of the Act, and 42 CFR 431.55, require that states assure waivers under this authority are cost-effective, and do not substantially impair access to services of adequate quality where medically necessary.

This waiver preprint is organized as follows:

Face Sheet	Key Information
Section A	Program Description
Section B	Monitoring Plan
Section C	Monitoring Results
Section D	Cost effectiveness
Appendices D1-7	Cost effectiveness data

This preprint incorporates relevant statutory requirements (see sections 1902, 1903, 1915, and 1932 of the Act), as well as pertinent regulations (see 42 CFR Parts 431, 434, and 438). Please note that states must still have MCO contracts and capitation payments prior approved by the CMS Regional Office, and must have PIHP and PAHP contracts and capitation payments reviewed and approved by the CMS Regional Office.

This preprint is not for use in authorizing managed care programs under sections 1905(t), 1915(a), or 1932(a) of the Act. Programs under those authorities are authorized through state plan amendments.

Features

This waiver preprint is designed to simplify the waiver application process. It has the following features:

- Use same document for initial and renewal. The State may use this waiver preprint to make an initial request to authorize a new 1915(b) waiver program, or

to request a renewal or amendment of an existing one. In addition, Sections A and B (Program Description and Monitoring Plan) need not be resubmitted at each renewal if there are few or no changes.

- Authorize multiple programs. The preprint is flexible enough to be used to authorize multiple managed care programs under a single waiver request. However, it is up to States to determine how many waiver programs they want to authorize in a given waiver request.
- Reduce duplication with other requirements. Federal regulations in 42 CFR 438 provide clear and consistent requirements related to beneficiary protections for all types of managed care programs; and for access and quality for capitated programs. As a result, in many places assurances of compliance with regulatory requirements will be sufficient to comply with waiver requirements related to Program Impact, Access, and Quality. Additional information may be required if a State requests a waiver of a provision within the regulation.
- Provide clear evaluation criteria. The preprint provides clear direction on the information needed and criteria used to evaluate waiver requirements related to Program Impact, Cost Effectiveness, Access, and Quality.

How to submit

What to include in submission. For initial or renewal requests, submit the items below. For amendments, see the next section.

- Signed cover letter (from the Governor, state cabinet members responsible for state Medicaid activities, the Director of the state Medicaid agency, or someone with authority to submit waiver requests on behalf of the Director)
- Face sheet
- Sections A-D (as applicable; see below)
- Appendices D1-7 (as applicable; see below)
- Any other state-specific attachments.

Number of copies/format. Please submit the following to the CMS Central Office:

- One original hard copy of the waiver preprint and attachments
- One electronic copy of the waiver and any attachments available electronically
- Four (4) copies of any waiver attachments not available electronically

At the same time, send at least one hard copy of the waiver request to the appropriate CMS Regional Office.

Where to send. For MCO programs, PCCM programs, PAHP programs covering dental or transportation services, and FFS selective contracting programs:

CMS, Center for Medicaid and State Operations
Attn: Director, FCHPG, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For PIHP/PAHP programs focusing on behavioral health, or on elderly and disabled populations:

CMS, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

Processing timelines. CMS must approve, disapprove, or request additional information for a waiver request submitted under section 1915(b) of the Act within 90 days of receipt, or else the request is deemed granted. When CMS requests additional information, the waiver request must be approved or disapproved within 90 days of CMS' receipt of the State's complete response to the request for additional information, or the waiver request is deemed granted. The 90-day time period begins (i.e., day number one) on the day after the day the State's waiver or response to request for additional information is received by the addressee (i.e., the Secretary, the CMS Central Office, or CMS Regional Office designee) and ends 90 calendar days later.

When Amendment Needed During Waiver Period

The State must submit an amendment for major changes, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, PCCM quality/access, monitoring plan, changes in payment rates, or changes in costs or trends that may jeopardize cost-effectiveness. Please submit replacement page(s) for relevant changes.

The same timelines and procedures described in the "How to Submit" section above apply to waiver amendments. Approval of a request to amend the waiver is effective from the date of approval through the end of the renewal period. The request must be submitted and approved prior to implementation of a change in the waiver program.

Instructions for Filling Out Sections A, B, and C

General instructions for filling out Sections A, B, and C are below. Each Section may have more detailed instructions. The preprint clearly indicates if a given item only applies to a certain type of managed care entity. If a given item does not apply, the State should indicate this by inserting "not applicable."

Assurance of compliance with requirements. The preprint includes assurances with compliance with applicable federal statutory, regulatory, and policy requirements related to managed care.

Exception: If the State is requesting a waiver of a provision of a federal managed care requirement, it must add language at the end of the assurance stipulating the waiver being requested, and what, if anything, the State will do instead.

Detail on discretionary items. In areas where the State has discretion, the State must describe what method it uses. For example, 42 CFR 438.10(c)(1) requires the State to identify prevalent non-English languages, but gives the State discretion in what methodology to use. For PCCM programs, the State has broader discretion in demonstrating how the waiver program impacts access and quality, so must describe in detail the standards and processes it uses.

Initial waiver request. If this is an initial waiver request, the State should fill out Sections A (Program Description), B (Monitoring Plan), D (Cost-Effectiveness) and Appendices in full. In Section C (Monitoring Results), the State must assure that in the renewal request, it will submit the results of its monitoring activities.

Renewal waiver request -- converting to new preprint. If this is the first time a State is using this preprint format, the State should fill out the preprint in full.

Renewal waiver request – once new preprint has been used. If the State has used this format for the previous waiver period, the State should fill out Sections C and D (Monitoring Results and Cost-Effectiveness) and Appendices D1-7 of the preprint in full. With respect to Sections A-B (Program Description and Monitoring Plan), the State has two options:

Option 1 – Submit sections in full. The State may want to consider this if there are numerous changes from how the program was operated and/or monitored compared to the previous waiver period.

Option 2 – Carry over from previous waiver period. If there are few or no changes to the Program Description or Monitoring Plan, the State need not re-submit these sections. Instead, it can indicate it will use the same Sections from the previous waiver period, and if needed, submit replacement pages for minor changes.

The State may choose different options for Section A versus Section B. Please indicate on the Facesheet which option the State uses.

Single program. Many areas of the preprint apply to all entity types (e.g. enrollment, information). However, if a given section does not apply to the type of entity in a single program waiver, please respond by inserting "Not Applicable."

Multiple programs. This preprint can be used for a combination of capitated and PCCM programs. However, not all programs will fit each item, or the answer to a given item may be different for PCCM versus a capitated program. If the State's response differs for either the capitated or PCCM program, please check the box if applicable and add narrative below to describe to which program(s) the checked box applies and how.

FFS selective contracting programs. If a State is only using section 1915(b)(4) authority to selectively contract FFS providers (i.e. who do not qualify as an MCO, PIHP, PAHP, or PCCM), the portions of the preprint that require assurances with managed care regulations and contracts do not apply. However, the State must still address program

impact, access, and quality, though they have discretion in how to do so. Please fill in the "1915(b)(4) FFS selective contracting" items within each section.

MMA 1915(b) Amendment Instructions

Any drug costs for Dual Eligibles that are in the waiver cost-effectiveness and no longer covered by Medicaid will need to be adjusted out of the 1915(b) waivers as of 1/1/2006.

Option 1: You may do this through a Waiver renewal submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1 adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

or

Option 2: through an extra amendment to your waiver submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1 adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

Qs and As from States regarding the modification to 1915(b) waivers

Q1: Since Medicaid must pay the federal government back for the amount of drug payments that Iowa paid for dual eligibles in 2003 after implementation of Medicare modernization, we are not sure that there will be any less amount that Medicaid paid for drugs. It is more indirect than before when Medicaid paid the costs directly, but the incidence is for drugs when we have to pay back the federal government. Also we will lose the drug rebate for the drugs we paid, which again we think may mean no savings to Medicaid for Medicare paying drugs for the dual eligibles.

A1: The calculation of state contribution and the overall cost to the State will not count against the waiver cost-effectiveness in future 1915(b) waivers. These are separate calculations.

Instructions for Filling Out Section D – Cost Effectiveness

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. Instead, 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.

The 1915(b) Cost-Effectiveness Instructions are divided into 3 major sections:

Section I.	Definitions and Terminology
Section II.	General Principles of the Cost-Effectiveness Test
Section III.	Instructions for Appendices

In addition there are seven Appendices:

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. The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska's actual experience or program structure.*

In addition, technical assistance is available through each State's CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

Actual Waiver Service Cost + Actual Waiver Administration Cost<= Projected Waiver Cost

I. Definitions and Terminology

The following terms will be used throughout this document and are defined below:

For Initial Waivers:

Historical Period

- BY = Base Year

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Conversion Waivers *(existing waivers which will "convert" from the former "with and without waiver" cost effectiveness test to the new cost effectiveness test described in these instructions)*:

Historical Period for first time a State completes the new cost effectiveness test

- BY = Base Year – CMS prefers 7/1/2001 – 6/30/2002

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Renewal Waivers:

Retrospective Waiver Period

- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

Form CMS-64: *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (MBES - formerly known as the HCFA-64) submitted by States as an accounting statement under Title XIX and Title XXI of the Social Security Act. The *Form CMS 64* is completed according to the reporting instructions in the State Medicaid Manual, Section 2500. Additional technical assistance is available through each State's CMS Regional Office. Each Regional Office will have a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests. In general, CMS-64 data is recorded based on the date that a payment was made to a provider.

Form CMS-64 Summary and CMS-64.9:

The *Form CMS-64 Summary* is an accounting of all expenditures for Medical Assistance **services and administration** for both MAP (CMS-64.9) and ADM (CMS-64.10) under Medicaid Title XIX and Title XXI Medicaid Expansion Groups including waiver expenditures. The Summary Sheet is generated from all worksheets entered by the State in support of each line item (including prior period adjustments). The *CMS-64.9* reports current expenditures for Medical Assistance **services** under the non-waiver programs.

Form CMS-64.10: The *Form CMS-64.10* is an accounting of **administrative** expenditures in Medicaid Title XIX for non-waiver programs.

Form CMS-64.21U: The *Form CMS-64.21U* is an accounting of **service and administrative** expenditures for the State Medicaid Expansion portion of the Children's Health Insurance Program (SCHIP) Title XXI. This form reports expenditures for children covered under 1905(u)(2) and (u)(3) of the Social Security Act.

Form CMS-64 F:

The *CMS-64 F Form* recaps all *CMS-64.21 Medicaid Expansion Forms* and Medicaid *CMS 64.9 Forms*. The *CMS-64 F Form* is summarized in the *CMS-64 Summary Form*. The *CMS-64 F* describes the source of the data on each line of the *CMS-64 Summary*. An example follows:
CMS-64 Summary, Line 6 MAP = $100
CMS-64 F, Line 6 MAP, *Form CMS-64.9* = $80
CMS-64F, Line 6 MAP, *Form CMS-64.21* = $20

Form CMS-64.9 Waiver: Same as the *Form CMS-64.9* except the *Form CMS-64.9 Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver program. The State will provide separate *CMS-64.9 Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.9 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.9 Waiver form* for expenditures that are not included on other *64.9 Waiver forms*. The *CMS-64.9 Waiver forms* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.9 Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.9 Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.9 Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.9 Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instruction section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the following Standard 1915(b) Waiver coding system:

- State Code: This will be the State's two-digit identifier (e.g., CA, FL, PA);
- Two digit waiver number;
- Followed by the two-digit waiver renewal number; and
- Followed by the two-digit consecutive waiver year.

Please work with your RO if you need guidance identifying this number. *Example: The Iowa Plan reporting for a waiver renewed on July 1, 2001 would use: IA07.R02.05. The Iowa Plan is Iowa's seventh waiver. It was renewed for the second time on July 1, 2001. If the first year of their waiver began July 1, 1997, the waiver year beginning July 1, 2001 would be 05.*

State Code	IA
Two-digit waiver number	07
Two-digit waiver renewal number	02
Two-digit consecutive waiver year	05

Form CMS-64.9P Waiver: Same as the *CMS-64.9 Waiver* except reporting a prior period adjustment.

Form CMS-64.10 Waiver: Same as the *Form CMS-64.10* except the *Form CMS-64.10 Waiver* reports Administration costs only for the population and services covered by the State's 1915(b) waiver program. The State will provide separate *CMS-64.10 Waiver forms* for each 1915(b) waiver program. The State must report administrative costs attributable to each waiver program on separate *CMS-64.10 Waiver forms*. Administrative costs that are applicable to more than one waiver program must be allocated to the respective *CMS-64.10 Waiver forms* based on a method approved by CMS (e.g., allocation based on caseload or Medical Assistance payments). Therefore, the *CMS-64.10 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If the State has specific questions regarding this requirement, please contact your State's RO. To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system. *Note: States should document their cost allocation methodology for administration costs between waivers in D.I.G.*

Form CMS-64.10P Waiver: Same as the *CMS-64.10 Waiver* except reporting a prior period adjustment.

Form CMS-64.21U Waiver: Same as the *Form CMS-64.21U* except the *Form CMS-64.21U Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver programs. Cost Effectiveness requirements apply only to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program. The State will provide separate *CMS-64.21U Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.21U Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.21U Waiver form* for expenditures that are not included on other *64.21U Waiver forms*. The *CMS-64.21U Waiver sheets* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.21U Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.21U Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a

single, separate *CMS 64.21U Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.21U Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instructions section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system.

Form CMS-64.21UP Waiver: Same as the *CMS-64.21U Waiver* except reporting a prior period adjustment.

Schedule D: Schedule D is a report of waiver expenditures by waiver year for a given waiver period that is generated within the Medicaid Statement of Expenditures for the Medical Assistance Program (MBES) when selected by an MBES user from the reports menu. The State will submit a Schedule D for the previous waiver period with each renewal submission.

Base Year: In an Initial Waiver (i.e., first submission of a new program's cost-effectiveness data), CMS requires all States to create a BY which can be used to project total expenditures for the projected waiver period (P1 and P2). The BY must be the most recent year that has already concluded. The State must justify the use of any other year as the base year. All expenditures in the BY will be verified by the RO. The BY expenditure and enrollment data should be the actual experience specific to the population covered by the waiver. The maximum time period between a BY and P1 should be five years. CMS recommends that States use the first day of a Federal quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Base Year for Conversion Waivers: In Conversion Renewal Waivers (i.e., existing 1915(b) waivers which will comply with these cost-effectiveness instructions ***for the first***), CMS will require all States to create a BY which can be used to project total expenditures for the projected waiver periods (P1 and P2). If possible, the BY should be a year which has already concluded and where no additional payments can be recorded. All expenditures in the BY will be verified by the RO. CMS prefers that states use 7/1/2001 – 6/30/2002 as their BY because it was prior to the announcement of the new test and would not allow states to increase costs after the announcement that there would be no retrospective review for the conversion renewal period. That base year is also complete and allows states to begin analysis in order to submit their waivers in a timely manner. If the State would like, CMS will negotiate a BY that has already been concluded other than 7/1/2001 – 6/30/2002. For waivers just renewed in 2003 under the old methodology, if a State begins reporting waiver expenditures by MEG in a timely fashion, the State may have a full year of data on the MBES system via the CMS-64 Waiver forms by the time the waiver is renewed in 2005. If this is the case, the State could use the Schedule D information for a waiver year in the most recent waiver period to complete their

upcoming renewal. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to adding into waiver cost projections.*

Caseload: The total number of individuals enrolled on a waiver at any given time is its caseload. Because cost-effectiveness is calculated on a PMPM, the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload. The standard measurement for caseload is member months.

Case mix: The payments and the PMPM costs of a waiver program are affected by the distribution of the caseload among different reporting categories (MEGs in a 1915(b) waiver). The relative distribution of a member months among MEGs is referred to as membership mix or "case mix". Anytime a State has a MEG with greater than average cost and a caseload growing at a faster rate than less expensive MEGs, the overall weighted average should account for casemix changes or there will be a false impression of the waiver not being cost-effective. *For example, in a State with 100 enrolled members, MEG 1 has a PMPM cost of $3,000 and has 25% of the member months (25 member months) in the base year. MEG 2 has a PMPM cost of $300 and has 75% of the member months (75 member months) in the base year. The overall weighted PMPM for BY with the base year casemix would be:*

$$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975 \qquad \frac{\text{BY PMPM x BY MM}}{\text{BY MM}} = \text{BY PMPM With Casemix for BY}$$

The State projects that the casemix and costs will remain the same in the future (P1). However, if in P1, the program's casemix changes so that MEG 1 has 30% of the member months and MEG 2 has 70% of the member months in P1. The overall weighted PMPM for P1 with the P1 casemix would be:

$$\frac{(\$3000 \times 30) + (\$300 \times 70)}{100} = \$1{,}110 \qquad \frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}} = \text{P1 PMPM With Casemix for P1}$$

In this case, because MEG 1 has a high cost, a relative distribution change from MEG2 to MEG 1 artificially inflates the PMPM if the State does not account for the changes in the casemix. The overall weighted PMPM for P1 with Casemix for BY

$$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975 \qquad \frac{\text{P1 PMPM x BY MM}}{\text{BY MM}} = \text{P1 PMPM With Casemix for BY}$$

Throughout this document, CMS has explained when to account for casemix changes and how to calculate those calculations. In determining whether to renew the waiver, States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. However, for the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one which accounts for casemix changes (to monitor for PMPM waiver cost-effectiveness) and another which does not account for casemix changes (to monitor for

overall growth in CMS-64 expenditures). These calculations are projected in Appendix D6 and explained in the instructions and Technical Assistance Guide.

Medicaid Eligibility Group (MEG) - A MEG is a population reporting category usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Each State will have at least one Title XIX MEG for a Medicaid 1915(b) waiver. If the State includes MCHIP populations under 1905(u)(2) and/or (u)(3) in the 1915(b) waiver, then the State will also have at least one Title XXI MEG. Each MEG's costs will be reported on a separate 64.9 Waiver Form (64.21U Waiver Form if the MEG is for an MCHIP population). States are held accountable for member month distribution changes within MEGs, but not between MEGs. In cases where significantly different costs exist between different populations, the State should consider separate MEGs to account for the likelihood of a change in the proportion of the enrollees being served in any single reporting group. The State should recognize the impact on cost trends of the increase in the proportion of membership, which would be associated with the higher cost group when determining cost-effectiveness. The State may want to consider a more complex reporting structure, which would attempt to recognize high-cost groups separately from low-cost groups. It is in a State's interest to group populations with similar costs and similar caseload growth together. *For example, a State has a program with 100 member months - 25% of which cost $3,000 and 75% of which cost $300. The State can choose to have a single MEG with a PMPM cost of $975 or two MEGS with a weighted PMPM of $975. If the State has a distribution shift between the two population groups so that there are relatively more expensive persons costing $3,000, the State will be held accountable for that redistribution effect if it has only one MEG and will not be held accountable if the State has two MEGS. The weighted-average PMPM Casemix for BY for the single MEG is $1,110. The weighted-average PMPM Casemix for BY for two MEGs is $975.*

One MEG

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) / 100	*= 975*	*($3000 x 30) + ($300 x 70) / 100*	= $1,110
BY PMPM x BY MM / BY MM	=BY PMPM With Casemix for BY	P1 PMPM x P1 MM / BY MM	=P1 PMPM With Casemix for BY

Two MEGs

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) / 100	*= 975*	*($3000 x 25) + ($300 x 75) / 100*	= 975
BY PMPM x BY MM / BY MM	=BY PMPM With Casemix for BY	(P1 PMPM x BY MM) + (P1 PMPM x BY MM) / BY MM	=P1 PMPM With Casemix for BY

Adjustments: Each State creates budget projections in a slightly different manner than other states. To address this, CMS has identified the most common adjustments states

make to base year data (in initial and conversion waivers) and R2 data (in renewal waivers). The State must document each adjustment made, what is meant by each adjustment in the State Completion Section, how that adjustment does not duplicate another adjustment made, and how each adjustment was calculated. For example, in the State Completion section, the State is asked to document the State Plan Services Trend Adjustment. The State Plan Services Trend Adjustment reflects the expected PMPM cost and utilization increases (e.g., service prices, practice patterns, and technical innovation) in the managed care program from R2 (BY for initial/conversion waivers) to the end of the waiver (P2). Trend adjustments may be State Plan service-specific. Adjustments are typically expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states may calculate a combined trend rate. Because the trend is expressed on a PMPM basis, the State should explain what is accounted for in the trend adjustment (i.e., cost and utilization increases). Any trend should not be duplicated in the State's adjustments for programmatic/policy/pricing adjustments. For example, a Legislative price increase would be explained and reflected in the programmatic/policy/pricing adjustment not under the State Plan Services Trend Adjustment. The State should document how the adjustments are unique and separate.

Trend: Growth in spending from one year to the next year. Growth may be due to cost and utilization increases. Growth due to external forces such as Legislative change or program/contract change should be documented separately under adjustments that include more than trend. If only a trend adjustment is allowed, then growth due to external forces is not allowed without a separate waiver amendment documenting additional savings. In this preprint, all adjustments are made on a PMPM basis. For the sake of simplicity, whenever trend appears alone it refers to a PMPM increase in the cost.

Comprehensive Waiver Criteria: When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test: 1) Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority; 2) Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc); or 3) State Plan services were procured using sole source procurement.

Expedited Test: States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. To be able to use the Expedited Test for a particular waiver, a State would need to submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria (see above) OR Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver, which meets the Comprehensive Waiver Criteria except for the transportation and dental waivers specifically exempted.

Projections in Renewal Waivers: In Renewal Waivers, State will use its actual experience R1 and R2 data to project its P1 and P2 expenditures from the endpoint of the previous waiver of R2. In each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Projected Waiver Period: P1 and P2 are projections of the Medicaid waiver program expenditures for the future two-year period for the population covered by the waiver.

Retrospective Waiver Period: R1 and R2 are the actual Medicaid waiver program expenditures in the historical two-year period for the population covered by the waiver. These R1 and R2 costs are compared to the P1 and P2 projections from the previous waiver submission. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to developing waiver cost projections.*

1915(b)(3) service: An additional service for beneficiaries approved under the waiver paid for out of waiver savings. The service is not in the State's approved State Plan. Capitated 1915(b)(3) services must have actuarially sound rates based only on approved 1915(b)(3) services and their administration subject to RO prior approval.

Acronyms used in this section
ADM - Administration
AI/AN – American Indian/Alaskan Native
BBA – Balanced Budget Act of 1997
BY – Base Year
CAP - cost allocation plan amendment
CE – Cost Effectiveness
CMS – Center for Medicare & Medicaid Services
Co. - County
CSHCN – Children with Special Health Care Needs
CY – Calendar Year
DRG - Diagnostic Related Group
DSH - Disproportionate Share Hospital Payments
EQR – External Quality Review
FFP – Federal Financial Participation
FMAP – Federal Medical Assistance Participation
MAP – Medical Assistance Program or services
FFS – fee-for-service
FQHC – Federally Qualified Health Center
FY- Fiscal Year
GME – Graduate Medical Education
HIO – Health Insuring Organization

MBES - Medicaid Statement of Expenditures for the Medical Assistance Program
MCO – Managed Care Organization
MCHIP – Medicaid-Expansion Children's Health Insurance Program
MEG – Medicaid Eligibility Group
MMIS – Medicaid Management Information System
P1 – Prospective Year 1
P2 – Prospective Year 2
PAHP -- Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Manager
PIHP – Prepaid Inpatient Health Plan
PMPM – Per Member Per Month
RHC – Rural Health Center
SPA – State Plan Amendment
PRO – Peer Review Organization
Q1 – Quarter 1
Q4 – Quarter 4
Q5 – Quarter 5
R1 – Retrospective Year 1
R2 – Retrospective Year 2
RO – Regional Office
SCHIP – State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System
Title XIX – Medicaid
Title XXI - State Children's Health Insurance Program
TPL – Third Party Liability
UPL – Upper Payment Limit

II. General Principles of the Cost-Effectiveness Test

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. In order to grant a 1915(b) waiver, a 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. The State will document program expenditures on the CMS- 64 for the same two-year period for the population covered by the waiver. In other words, a State initially projects spending and documents on an on-going basis that the actual expenditures are at or below the projected amount.

In order for CMS to renew a 1915(b) waiver, a State must demonstrate that it was cost-effective during the retrospective two-year period and must create waiver cost projections that will be used to determine cost-effectiveness for the prospective two-year period. The cost-effectiveness test is applied to the combined two-year waiver period, not to each individual waiver year or portion of a year.

The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. States no longer need to demonstrate that

"with waiver" costs are lower than "without waiver" costs. Instead, States must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. Retrospectively, the State will document that program expenditures were less than or equal to these projections. As with all elements of 1915(b) waivers, States may amend their cost-effectiveness projections if the waiver program changes or if additional information documents that the projections are inaccurate and should be modified accordingly.

Each Initial Waiver submission will include a State's projected expenditures for the upcoming two year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2).

For each Renewal Waiver submission, a State will demonstrate cost-effectiveness for the retrospective waiver period by showing that the actual expenditures for retrospective years one and two (R1 and R2) did not exceed what the State had projected it would spend (P1 and P2) for the same two-year period on a per member per month (PMPM) basis for the population covered by the waiver. In other words, a State must compare what it had initially projected it would spend to what it actually spent over the waiver period and show that the actual expenditures came in at or under the projected amount. *Please note that for Conversion Waivers, CMS will not require a retrospective cost-effectiveness test. The State is only allowed a single Conversion Waiver, the first time the State submits a waiver renewal after the announcement of this new method.*

In order to project expenditures for the prospective waiver period, a State must use the actual historical expenditures from its base year (for an initial or conversion waiver) or from the past waiver period (R1 & R2 for a renewal waiver) as the basis for its cost effectiveness projection, adjusting for future changes in trend (including utilization and cost increases), and other adjustments acceptable to CMS. By always using actual historical expenditures from the most recent waiver period as the basis for the projection, the cost-effectiveness test for a waiver program will be "rebased" upon each renewal. *Note: this applies to both capitated and FFS services within 1915(b) waivers. The State must document that actual costs claimed on the CMS-64 were used to document the Actual Waiver Cost in Appendix D3.*

All 1915(b) waivers will use this cost-effectiveness test, regardless of the type of waiver program or the delivery system under the waiver.

All Medicaid Medical Assistance program expenditures (fee-for-service and capitated services) related to the services covered by the waiver will be reported for the population enrolled in the waiver. Because waiver providers can affect the costs of services not directly included in the waiver, CMS is requiring that States include **all Medicaid Medical Assistance program expenditures related to the population and services covered by the waiver, not just those services under the waiver,** in developing their cost-effectiveness calculations. See the detailed instructions below for additional guidance.

CMS will evaluate cost-effectiveness based on all Medicaid expenditures for waiver enrollees impacted by the waiver, even those expenditures that are outside the capitation rate or do not require a PCCM referral. These services are generally referred to as "wrap-around" or "carved-out" services and may include such services as pharmacy or school-based services that may be paid on a fee-for-service (FFS) basis for the population covered by the waiver. See the detailed instructions below for additional guidance. Additional guidance is also available in the technical assistance guide for cost-effectiveness. Each State will need to work with CMS to determine whether or not services that are not explicitly under the waiver should be included in the cost-effectiveness calculations.

Because all affected Medicaid Medical Assistance program expenditures for waiver enrollees will be counted in cost-effectiveness calculations, there will essentially be no difference in the extent to which services are impacted by either a PCCM system or capitated program cost-effectiveness test. Initial waivers with both PCCM and capitated delivery systems may need to make some specific adjustments in PCCM system expenditures as noted in the **State Completion Section D.I.I Special Note for Capitated and PCCM combined initial waivers**.

State administrative costs associated with the program and population enrolled in the waiver will also be reported. Administrative costs include, but are not limited to, State expenditures such as enrollment broker contracts, contract administration, enrollee information and outreach, State utilization review and quality assurance activities, State hotline and member services costs, the cost of an Independent Assessment, External Quality Review (EQR), actuary contracts, and administrative cost allocation (salaries).

All administrative and service costs should be calculated on a per member/per month basis. States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. States should have total PMPM actual waiver expenditures for the two-year period equal to or less than the corresponding total PMPM projected waiver expenditures for that same period. For the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one examining aggregate projected spending compared to the aggregate CMS-64 totals and the second examining PMPM spending compared to PMPM projections. *See the instructions for Appendix D6 for the explanation of the two calculations and detailed instructions on how to calculate and monitor each test.* **For the ultimate decision of cost-effectiveness (i.e. the decision to renew each waiver), the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.**

Cost-effectiveness will be calculated on a total PMPM basis, which is comprised of both service and administration costs.

CMS will track and evaluate waiver cost effectiveness using expenditure data as reported on the CMS-64 and will be measured in total computable dollars (Federal and State share). All waiver expenditures will be reported on the CMS-64.9 Waiver, CMS-64.21U

Waiver, or CMS-64.10 Waiver forms on a quarterly basis. (Data from the CMS-64.21U Waiver form will be used if the State enrolls its Medicaid-expansion SCHIP population in the waiver.)

All expenditures are based on the CMS-64 Waiver forms, which are based on date of payment, not date of service. States will itemize all expenditures for the population covered under the Waiver into each of the main service categories in the CMS-64 Waiver forms. These forms have been cleared by OMB (No. 0938-0067). The *Form CMS-64.9 Waiver* for Medical Assistance payments includes the major categories of service: inpatient hospital services, physician services, dental, clinic, MCO capitation, etc. Administrative expenditures will be reported on the CMS-64.10 Waiver form accordingly. *Note: please ensure that the State's projections for initial, conversion, and renewal waivers are projections for date of payment as well.*

States with multiple 1915(b), 1915(c), and 1115 waivers that have overlapping waiver populations will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the *CMS-64 Summary*.

All actual expenditures reported and used as the basis for a cost effectiveness projection must be verified by the RO.

The expenditures and enrollment numbers for voluntary populations (i.e., populations that can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in State's 1915(b) waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers. If the State wants to include voluntary populations in the waiver, then the expenditures and enrollment numbers for that population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in their waiver are required to submit a written explanation of how selection bias will be addressed in the waiver cost-effectiveness calculations. *Note: This principle does not change the historic practice of requiring States to include the experience of a voluntary MCO population in a mandatory PCCM waiver if a beneficiary can be auto-assigned to one of the delivery systems.*

States with 1932 managed care SPA programs with an overlapping 1915(b) waiver will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the CMS-64 Summary.

Incentive payments will be included in the cost effectiveness test. Incentives included in capitated rates are already constrained by the Medicaid managed care regulation at 42 CFR 438.6(c) to 105% of the capitated rates based on State Plan services. If there are any incentives in FFS/PCCM, those payments must be applied under the cost-effectiveness test. For example, if PCCM providers are given incentives for reducing utilization, the incentives are limited to the savings of State Plan service costs under the waiver. This policy creates a restraint on the FFS/PCCM incentive costs. States should ensure that all incentives are reported in renewal Actual Waiver Costs in **Appendix D3**.

1915(b)(3) waiver services will be included in the cost effectiveness test. In general, States cannot spend more on 1915(b)(3) services than they would save on State Plan services.

Cost Effectiveness requirements apply to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program in the Medicaid delivery system.

Comprehensive Waiver Criteria - When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test:

- Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority,
- Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc), or
- State Plan services were procured using sole source procurement (Sole source procurement means non-open, non-competitive procurement not meeting the requirements at 45 CFR 74.43). States must utilize the Comprehensive Cost Effectiveness Test to apply for and renew 1915(b) waivers that award services contracts using procurement methods meeting the criteria in 45 CFR 74.44 (e). Most competitive procurements resulting in a single contractor are not considered sole-source procurement under the 45 CFR 74.44(e) criteria. The State should verify the regulatory requirements and use the expedited test only if all expedited criteria are met.

Expedited Test – CMS is proposing a waiver-by-waiver test to expedite the processing of certain renewal waivers. States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. States will simply submit *Schedule D* from MBES to CMS along with projections for the upcoming waiver period (**Appendices D1, D2.S, D2.A, D4, D5, and D6 and D7**). For additional guidance, please see the Cost-effectiveness Technical Assistance Manual. To be able to use the Expedited Test for a particular waiver, a State would need to:

- Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria, OR
- Submit a separate 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver that

meets the Comprehensive Waiver Criteria except for transportation and dental waivers as noted below.

Cost-effectiveness for waivers of only transportation services or dental pre-paid ambulatory health plans (PAHPs) are processed under the expedited test if the transportation or dental waiver alone meets the expedited criteria. In this instance, States should not consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. If enrollees in a transportation or dental waiver are also enrolled in pre-paid inpatient health plans (PIHPs), MCOs, or PCCMs under separate waivers or separate SPA authority, the costs associated with dental or transportation services should not be included in any other 1915(b) waiver cost effectiveness test.

III. Instructions for Appendices

Step-by-Step Instructions for Calculating Cost-Effectiveness

Appendix D1 – Member Months

Document member months in the Base Year (BY)/ Retrospective Waiver Period (R1 and R2) and estimate projected member months in the upcoming period (P1 and P2) on a quarterly basis. Actual enrollment data for the retrospective waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed for RO monitoring on a quarterly basis. States will not be held accountable for caseload changes. This data is also useful in assessing future enrollment changes in the waiver.

States must document the number of member months in the waiver for the retrospective waiver period (R1 and R2) for renewal waivers and in the base year (BY) for initial and conversion waivers.

For initial or conversion waivers, document member months from the Base Year (BY). For renewal waivers, document member months from Retrospective Waiver Period (R1 and R2). Categorize all enrollees into Medicaid Eligibility Groups (MEG). A MEG is usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Please note that States will use these same MEGs to report expenditures on the CMS 64.9 Waiver, CMS 64.10 Waiver, and/or CMS 64.21U Waiver.

CMS recommends that the State analyze their capitated program's rate cell categories to support the development of the Medicaid Eligibility Group (MEG) detail within the cost-effectiveness analysis. A MEG is a reporting group collapsing rate cell categories into groups that the State anticipates will have similar inflation and utilization trends, as well as by program structure (eligibility, geography, service delivery, etc). Every MEG created will mean a separate CMS 64.9 Waiver form, etc and results in additional quarterly expenditure reports to CMS. Selecting the right number of MEGs is a very important step. *See the MEG definition above for further guidance.* States should use the

64.9 and 64.21 waiver form population categories for any renewals. *For example, Nebraska chose to divide their single waiver into four MEGs. Nebraska has Medicaid Expansion SCHIP populations in their 1915(b) waiver, which automatically means that 2 MEGs are necessary (one for TXIX and one for MCHIP). In addition, Nebraska chose to separate costs for Special Needs children's populations and AI/AN populations from all other enrollees because of the structure of their program and differential caseload trends that they anticipate. During the waiver, Nebraska will report waiver costs on two separate 64.9 Waiver forms ((Medicaid (No CSHCN or AI/AN – PIHP only), and Medicaid (CSHCN or AI/AN– MCO/PIHP/PCCM) and two separate 64.21U Waiver forms (MCHIP (No CSHCN or AI/AN– PIHP only), MCHIP (CSHCN or AI/AN – MCO/PIHP/PCCM)). In Nebraska's renewal they would have a MEG for each of the four populations)*.

Step 1. List the Medicaid Eligibility Groups (MEGs) for the waiver. List the base year eligible member months by MEG. Please list the MEGs for the population to be enrolled in the waiver program. The number and distribution of MEGs will vary by State. For renewals, if the State used different MEGs in R1 and R2 than in P1 and P2, please create separate tables for the two waiver periods (the State will be held accountable for caseload changes between MEGs in this instance). The base year for an initial waiver should be the same as the FFS data used to create the PMPM Actual Waiver Costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted in the Appendix and explained in the State Completion Section of the Preprint.

Step 2. Project by quarter, the number of member months by MEG for the population that will participate in the waiver program for the future waiver period (P1 and P2). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in R1 and R2. List the quarterly member/eligible months projected in each MEG by quarter. States who are phasing in managed care programs or populations may choose to have quarterly estimates that are not equal (i.e., P1 Q1 reflects a different enrollment than P1 Q4).

Step 3. Total the member/eligible months for each quarter and year. Calculate the annual and quarterly rate of increase/decrease in member months over the projected period. Explain the rate of increase/decrease in the State Completion section.

Appendix D2.S - Services in Waiver Cost

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

Step 1. List each State Plan service and 1915(b)(3) service under the waiver and indicate whether or not the service is:

- State Plan approved;
- A 1915(b)(3) service;
- A service that is included in a capitation rate; paid to either MCOs, PIHPs, or PAHPs, (whichever is applicable);

- A service that is not a waiver service but is impacted by the MCOs, PIHPS, or PAHPs (whichever is applicable);
- a service that is included in the PCCM FFS reimbursement.

The chart in **Appendix D2.S** should be modified to reflect each State's actual waiver program. States should indicate which services are provided under each MEG, if the benefit package varies by MEG. Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

Step 2. Please note any proposed changes in services on Appendix D2.S with a *. *See the Nebraska example for illustration purposes.*

Step 3. List the State Plan Services included in the Actual Waiver costs (only State Plan Service costs may be included in an initial waiver's Actual Waiver Costs). Please also list the 1915(b)(3) non-State Plan services proposed in the initial waiver and any 1915(b)(3) services included in the Actual Waiver costs for a conversion or renewal waiver. For an MCO/PIHP/PAHP waiver, include services under the capitated rates, as well as services provided to managed care enrollees on a fee-for-service wraparound basis (note each). For a PCCM program, include services requiring a referral, as well as services provided to waiver enrollees on a wraparound basis. Please add lines and specify as needed.

(Column B Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column C Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column D Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column E Explanation) MCO Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO. If a 1915(b)(3) service in an MCO is capitated, please mark this column.

(Column F Explanation) Fee-for-Service Reimbursement impacted by MCO: Check this column if the service is not the responsibility of the MCO, but the MCO or its contracted providers can affect the utilization, referral or spending for that service. *For example, if the MCO is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription*. Do not mark services NOT impacted by the MCO and not included in the cost-effectiveness analysis. *For example, a State would not include Optometrist screening exams in states where vision services are not capitated, a PCP referral is not required for payment, and PCP do not refer or affect patient access to vision screening examinations.*

(Column G Explanation) PCCM Fee-for-Service Reimbursement: Check this column if this service will be included in the waiver and will require a referral/prior authorization or if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the waiver. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

(Column H Explanation) PIHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PIHP. If a 1915(b)(3) service is capitated in a PIHP, please mark this column.

(Column I Explanation) Fee-for-Service Reimbursement impacted by PIHP: Check this column if the service is not the responsibility of the PIHP, but is impacted by it. For example, if the PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PIHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PIHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

(Column J Explanation) PAHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PAHP. If a 1915(b)(3) service is capitated in a PAHP, please mark this column. *Note: the Nebraska example did not include a PAHP and so did not include this column.*

(Column K Explanation) Fee-for-Service Reimbursement impacted by PAHP: Check this column if the service is not the responsibility of the PAHP, but is impacted by it. For example, if the PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PAHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PAHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for*

guidance. Note: the Nebraska example does not include a PAHP delivery system and so did not include this column.

Note: Columns C and D are mutually exclusive. Columns E and F are mutually exclusive for the MCO program. Columns H and I are mutually exclusive for the PIHP program. Columns J and K are mutually exclusive for the PAHP program. Each service should have a mark in columns C or D. If the State has more than one MEG, Appendix D2 should reflect what services are included in each MEG.

Chart: Inclusion of Services in Cost-Effectiveness Test

Note: All references to the single CMS 64.9 Waiver form refer to a 1915(b) waiver that does not include any SCHIP Medicaid expansion populations. If a 1915(b) includes an SCHIP Medicaid expansion population, the State would also complete a CMS 64.21U Waiver form for the applicable SCHIP Medicaid expansion population. In addition, the State can always choose to divide its data into MEGs for additional reporting categories. Services included in other 1915(b) waivers should be excluded and not counted under two separate 1915(b) cost-effectiveness tests. Services in 1915(c) waivers should only be included for concurrent 1915(b)/1915(c) waivers. Services for 1115 Demonstration waivers should only be included if the 1915(b) population is being used as an impacted population in the 1115 Demonstration. *See the Technical Assistance Manual for additional information.*

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
Medicaid beneficiary is enrolled only in 1915(b) for transportation	PAHP	Transportation only	Transportation	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for dental	PAHP	Dental only	Dental	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for mental health – remaining services are FFS or under 1932 SPA *(examples: rural Nebraska and Iowa)*	PIHP	Mental Health and Substance Abuse are under waiver. Pharmacy, rehabilitation services, and inpatient psychiatric services for individuals under age 21 are fee-for-service.	All Mental Health, Substance Abuse, Pharmacy, Inpatient psychiatric services for individuals under age 21, and Rehabilitation services for waiver enrollees are reported on single *CMS-64.9*	All other Medicaid services

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
			Waiver form for the 1915(b) waiver.	
Medicaid beneficiary is enrolled in one 1915(b) waiver for mental health and MCO services *(examples: urban Nebraska special needs children)*	PIHP and MCO	All services	All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form*	None.
Medicaid beneficiary is enrolled in 1915(b) for mental health and separate 1915(b) for MCO	PIHP and MCO	All services except pharmacy are in one waiver or the other	The State divides all services for waiver enrollees into two *CMS-64.9 Waiver forms*: one for the mental health 1915(b) and the other for the MCO 1915(b).	None.
Medicaid beneficiary is enrolled in a single1915(b) for mental health and PCCM *(examples: urban Nebraska special needs children)*	PIHP and PCCM	All services except school-based services	All services including school-based services for waiver enrollees are reported on a *CMS-64.9 Waiver form*	None.
Medicaid beneficiary is enrolled in 1915(b) PCCM or MCO	PCCM and/or MCO	All services	All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form*	None.

Appendix D2.A Administrative Costs in the Waiver
Document the administrative costs included in the Actual Waiver Cost.

Step 1. Using *CMS-64.10 Waiver Form* line items numbers and titles, document the State's administrative costs in the waiver. **Do not include MCO/PIHP/PAHP/PCCM entity administration costs.** For initial waivers, this will include only fee-for-service

costs such as MMIS and SURS costs. For renewal waivers and conversion waivers, the administrative costs will include managed care costs such as enrollment brokers, External Quality Review Organizations, and Independent Assessments. Add lines as necessary to distinguish between multiple contracts on a single line in the CMS-64.10. *Note: PCCM case management fees are not considered State Administrative costs because CMS matches those payments at the FMAP rate and states claim those costs on the CMS-64.9 Waiver form. Services claimed at the FMAP rate should be reported on* ***Appendix D2.S*** *and not reported on* ***Appendix D2.A****.*

Step 2. The State should allocate administrative costs between the Fee-for-service and managed care program depending upon the program structure. For example, for an MCO program, the State might allocate the administrative costs in the Administrative Cost Allocation Plan to the MCO program based upon the number of MCO enrollees as a percentage of total Medicaid enrollees. For a mental health carve out enrolling most Medicaid beneficiaries in the State, allocate costs based upon the mental health 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. Explain the cost allocation process in the preprint.

Appendix D3 – Actual Waiver Cost

Document Base Year and Retrospective Waiver Period expenditures (actual expenditures in the BY for initial/conversion waivers and R1 and R2 in renewal waivers). States that are eligible to use the expedited process for certain waivers need not complete Appendix D3; instead, attach the most recent waiver Schedule D. For all other submissions, States should complete **Appendix D3**.

The State must document the total expenditures for the services impacted by the waiver as noted in **Appendix D2.S**, not just for the services under the waiver. For an Initial Waiver or Conversion Waiver, the State must document the expenditures used in the BY PMPM. **All expenditures in the BY will be verified by the RO.** For a Renewal Waiver, the State must document the actual expenditures in the retrospective two-year period (R1 and R2) separating administration, 1915(b)(3), FFS incentives, capitated, and fee-for-service State Plan expenditures as noted. **Actual expenditures will be verified by the RO on a quarterly basis by comparing projections to actual expenditures and other routine audit functions.**

The actual expenditures used in the cost-effectiveness calculations should include all Medicaid program expenditures related to the population covered by the waiver, not just those services directly included in the waiver. If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64. Incentives to capitated entities are reflected in **Column D of Appendix D3** of the spreadsheets. Fee-for-service incentives, such as incentives to PCCM providers, are noted separately in **Column G of Appendix D3**. 1915(b)(3) services in the initial waiver will always be zero in **Column H of**

Appendix D3 of the initial waiver because 1915(b)(3) services are a result of savings under the waiver and cannot exist prior to the waiver.

Actual expenditures are based on the CMS-64 Waiver forms, which are based on date of payment not date of service.

States must separately document actual Medical Assistance service expenditures and actual State administrative costs related to those services. Actual case management fees paid to providers in a PCCM program should be included as service expenditures.

Since a State may be in the process of developing a Renewal Waiver during the second year of the waiver (R2) period (to avoid an extension), the State use only data from the Schedule D and document the number of months of data used on Appendix D7. Appendix D7 will recalculate the formulas based upon the amount of data available to the State. The State should not project any actual expenditures that are not yet available for R2.

Should a State request and be granted one or more 90-day temporary extension(s) for submitting a Renewal Waiver, the following process applies depending on the length of the extension:

- For three or fewer 90-day temporary extensions (a period of less than one year after the expiration of the waiver), the State must demonstrate cost-effectiveness over the original two-year period included in the waiver. In other words, if a waiver considered years CY 2003 and CY 2004 as P1 and P2, respectively, and 2 three-month temporary extensions were obtained, the State would still be required to demonstrate cost-effectiveness for calendar year 2003 and 2004 by comparing actual expenditures (R1 and R2) to the projected expenditures (P1 and P2) for these two years in aggregate. In this scenario, actual expenditures for the entire R2 period may be available to support the Renewal Waiver calculations.
- For four or more temporary extensions (a period of one year or more after the expiration of the waiver), the State must demonstrate cost-effectiveness for the original two-year period included in the waiver as previously described and in addition demonstrate cost-effectiveness for the one-year extension period (to the extent data is available – in this case CY2005). In this scenario, actual expenditures for the entire R2 period will be available to support the Renewal Waiver calculations, but the extension year may require projecting actual expenditures. The State's extension year will be compared to the expenditure projections as if P2 were 24 months rather than 12 months.

Number of Extensions	Demonstration of Cost-Effectiveness	Example
3 or fewer 90-day temporary extensions	Demonstrate cost-effectiveness for the original two-year period	Waiver CY2003 and CY2004 2 Extensions through 7/1/2005

		State CE covers only CY2003 and CY2004
4 or more temporary 90-day extensions	Demonstrate cost-effectiveness for the original two-year period and for each additional one-year extension period	Waiver CY2003 and CY2004 4 Extensions through CY2005 State CE covers CY2003, CY2004, and CY2005

Fee-for-service Institutional UPL Expenditures to include and not include in the cost-effectiveness analyses.

- **Transition amounts should be excluded** from the Cost-Effectiveness test. A transition amount is what the State spent over 100% of the institutional fee-for-service UPL (i.e., the "excess"). The State should isolate the excess amounts to remain in fee-for-service outside of the waiver and include only the amount under 100% of the FFS UPL in the Cost-effectiveness analysis.
- **Supplemental payments at or below 100% of the UPL should be included** in the cost-effectiveness analysis. States that are not transition States may in fact make supplemental payments below or up to the 100% UPL and that money should be included in the cost-effectiveness. The entire amount of the supplemental payment at or below the UPL should be in the 1915(b) analysis.

States should contact their RO for additional State-specific guidance on the inclusion and exclusion of Fee-for-service Institutional UPL payments.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.** The renewal will list the MEGS twice – once for R1 and once for R2. *See the example spreadsheets.*

Step 2. List the BY eligible member months (R1 and R2 member months, if a renewal). *See the example spreadsheets.*

Step 3. List the base year (R1 and R2 if a renewal) aggregate costs by MEG. Actual cost and eligibility data are required for BY (R1 and R2) PMPM computations. Aggregate Capitated Costs are in Column D. Aggregate FFS costs are in Column E. Add D+E to obtain the State Plan total aggregate costs in Column F. List FFS incentives in Column G. In a renewal or conversion waiver, list 1915(b)(3) aggregate costs in Column H. List Administrative costs in Column I. For an initial waiver, these PMPM costs are derived from the State's MMIS database or as noted from the explanation in the State Completion section under **Section D.I.H.a** Comprehensive Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D and with additional ad hoc reporting for 1915(b)(3) services and FFS incentive payments. The State must track FFS incentive and 1915(b)(3) payments separately (those costs will not be separately identified on Schedule D). The State must document that State Plan service aggregate costs amounts were reduced by the amount of FFS incentives and 1915(b)(3) costs spent by the State. To calculate the PMPM by MEG for 1915(b)(3) services, the State should divide the cost of 1915(b)(3) service costs by MEG for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for FFS incentives, the State

should divide the cost of FFS incentives for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for State Plan Services, the State should divide the cost of State Plan Services from Schedule D (minus FFS incentives and 1915(b)(3) service costs) for R2 and divide by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted.*

Step 4. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.

Step 5. The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training conducted by CMS in April 2003 and States should pay particular attention to this detail.***

Step 6. Total the base year capitated costs and fee-for-service costs to derive the total base year costs for services. Add all costs (F, G, H, and I) to obtain total waiver aggregate costs.

Step 7. Divide the base year (BY) costs by the annual BY (divide the R1 costs by the R1 MM or the R2 costs by the R2 MM, if a renewal) member months (MM) to get PMPM base year (R1 or R2) costs**.** In this instance, the State calculates the overall PMPM for BY (the overall PMPM for R1 or the overall PMPM for R2 in a renewal). The State will divide the costs of the program by the caseload for the same year from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each year of the waiver (R1 and R2). In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

Initial/Conversion	Renewal R1	Renewal R2
BY Costs BY MM	R1 Costs R1 MM	R2 Costs R2 MM
Overall PMPM for BY	Overall PMPM for R1	Overall PMPM for R2

Appendix D4 – Adjustments in the Projection

Document adjustments made to the BY or R1 and R2 to calculate the P1 and P2. The State will mark the adjustments made and document where in Appendix D5 the adjustment can be found. All adjustments are then explained in the State Completion portion of the Preprint.

Waiver Cost Projection Adjustments: On **Appendix D4**, check all adjustments that the State applied to the R1/R2 or BY data. In Column D, note the location of each adjustment in **Appendix D5**. Note: only the adjustments listed may be made. If the State has made another adjustment, the State should obtain CMS approval prior to its use. Complete the attached preprint explanation pages and include attachments as requested. ***Note:*** *(Initial Waiver only) Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- some adjustments to the Waiver Cost Projection in an initial waiver must be made due to a policy decision in the capitated program. Those adjustments are permitted only to the capitated programs and need an offsetting adjustment to the PCCM Waiver Cost Projections in order to make the PCCM costs comparable to the Actual Waiver Costs. Please see the State Completion Section of the initial waiver for further instructions if the State has a combined capitated and PCCM cost-effectiveness analysis.*

Appendix D5 – Waiver Cost Projection

Each time a waiver is renewed, a State must develop a two-year projection of expenditures. States must calculate projected waiver expenditures (P1 and P2) for the upcoming period. Projected waiver expenditures for P1 and P2 should be created using the State's actual historical expenditures (e.g., BY data for an Initial or Conversion Waiver, or R2 data using R1 & R2 experience to develop trends for a Renewal Waiver) for the population covered under the waiver and adjusted for changes in trend (including utilization and cost increases) and other adjustments acceptable to CMS. For example, in an Initial or Conversion Waiver, a State should use its actual BY data to project its P1 and P2 expenditures. In a Renewal Waiver, a State should use its actual experience in R1 and R2 to project trends for its P1 and P2 expenditures from the endpoint of the previous waiver of R2. As a result, in each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2.

Projected waiver expenditures must include all Medicaid expenditures for the population included in the waiver, not just those services directly included in the waiver, calculated on a PMPM basis and including administrative expenses. (For example, a State must include services that are outside of the capitated or PCCM program.) If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64.

In projecting expenditures for the population covered by the waiver, States must use trends that are reflective of the regulation requirements for capitated rates and fee-for-service history for fee-for-service rates. The State must document and explain the creation of its trends in the State Completion Section of the Preprint. CMS recommends that a State use at least three years of Medicaid historical data to develop trends. States must use the State historical trends for the time periods where actual State experience is available. States must use the prescribed methods (see the State Completion Section) for

inflating FFS incentives (no greater than the State Plan trend rate), 1915(b)(3) services (the lower of State Plan service and actual 1915(b)(3) trend rates), and administration (historic Medicaid administration trend rates unless the State is using sole source procurement to procure State Plan services)

States need to make adjustments to the historical data (BY for initial/conversion and R2 for renewals) used in projecting the future P1 and P2 PMPMs to reflect prospective periods. For Renewals, these adjustments represent the impact on the cost of the State's Medicaid program from such things as: State Plan service trend, State Plan programmatic/policy/pricing changes, administrative cost adjustments, 1915(b)(3) service trends, incentives (not in the capitated payment) adjustments, and other. Since States are required to consider the effect of all Medicaid costs for the waiver population, States should consider adjustments that might impact costs for services not directly covered under the waiver (i.e., global changes to the Medicaid program).

1915(b)(3) services must be paid out of savings in the future years (P1 and P2) of the waiver. Under 1915(b)(3) authority, states can offer additional benefits using savings from providing State Plan services more efficiently. The following principles and requirements will be used to evaluate the cost-effectiveness of waiver requests that include 1915(b)(3) services. The principles are intended to highlight concepts and policy goals (i.e., **what** the policy guidance is intended to accomplish). The requirements are intended to outline operational details (i.e., **how** the policy goals will be pursued).

2) Aggregate spending

- *General principle*—Under a 1915(b) waiver, combined spending on State Plan and 1915(b)(3) services cannot exceed what would have occurred without the waiver. In other words, States cannot spend more on 1915(b)(3) services than they save on State Plan services under the waiver.
- ➢ *Requirement*—Combined spending on State Plan and 1915(b)(3) services cannot exceed projected spending during any given waiver period.

3) Base-year spending (R2 for renewals) (for waiver projections)

- *General principle one*—Spending for 1915(b)(3) services should not exceed the cost of providing these services.
- *General principle two*—Spending for 1915(b)(3) services should not exceed the "budget" for these services, as determined in a state's waiver application.
- ➢ *Requirement (for initial waiver applications)*—The base year amount for 1915(b)(3) services under a new waiver application is limited to the lower of:
  a. Expected costs for the 1915(b)(3) services or
  b. Projected savings on State Plan services
- ➢ *Requirement (for Renewals and Conversion Renewals)*—The base year (R2 for renewals) amount for projecting spending on 1915(b)(3) services under a waiver renewal is limited to the lower of:
  a. Actual costs for 1915(b)(3) services under the current waiver or

b. Projected costs for 1915(b)(3) services under the current waiver (P2 in the previous submittal)

4) Growth in spending (price increases and use of services, but not changes in enrollment)

- *General principle one*—Growth in spending on 1915(b)(3) services cannot exceed growth in spending for State Plan services under the waiver. (This ensures that savings on State Plan services for both initial waiver and renewal periods finance spending for 1915(b)(3) services.)
- *General principle two*—Growth in spending on 1915(b)(3) services cannot exceed historical growth in spending for these services. (This ensures that growth in spending on waiver services is reasonable for the particular services.)

➢ *Requirement*—Growth in spending for 1915(b)(3) services is limited to the lower of:

a. The overall rate of trend for State Plan services, or
b. State historical trend for 1915(b)(3) services

5) Covered services

- *General principle*—If the State wants to expand 1915(b)(3) services, the State must realize additional savings on State Plan services to pay for the new services.

➢ *Requirement*—Before increasing its budget for 1915(b)(3) waiver services, the State must submit an application to CMS to modify its waiver (or document the modification in its renewal submittal). This application must show both:

a. How additional savings on State Plan services will be realized, and
b. That the savings will be sufficient to finance expanded services under the waiver

- *Special case*—A State also could be required to cut back (b)(3) services because of increased use of State Plan services.

5) Payments

- *Requirement*—As a condition of the waiver, capitated 1915(b)(3) payments must be calculated in an actuarially sound manner.

States must calculate a separate capitation payment for 1915(b)(3) services using actuarial principles and the same guiding principles as the regulation at 42 CFR 438.6(c) -with the exceptions that the 1915(b)(3) rates are based solely on 1915(b)(3) services approved by CMS in the waiver and the administration of those services. The actual payment of the 1915(b)(3) capitated payment can be simultaneous with the payment of the State Plan capitated payment and appear as a single capitation payment. However, the State must be able to track and account for 1915(b)(3) expenditures separately from State Plan services.

1915(b)(3) services versus 42 CFR 438.6(e) services. Under a 1915(b) waiver, 1915(b)(3) services are services mandated by the State and paid for out of State waiver savings. 42 CFR 438.6(e) services are services provided voluntarily by a capitated entity out of its capitated savings. A State cannot mandate the provision of 42 CFR 438.6(e) services. In order to provide a service to its Medicaid beneficiaries, the State must have authority under its State Plan or through a waiver such as the 1915(b)(3) waiver. 1915(c) and 1115 Demonstration waivers also have authority for the provision of services outside of the Medicaid State Plan. CMS will match managed care expenditures for services under the State Plan or approved through an approved waiver. The State cannot mandate the provision of services outside of its State Plan or a waiver.

Initial waivers must estimate the amount of savings from fee-for-service that will be expended upon 1915(b)(3) services in the initial waiver. The State must document that the savings in state plan services, such as reductions of utilization in hospital and physician services, are enough to pay for the projected 1915(b)(3) services. If the State contends that there is additional state plan savings generated from the 1915(b)(3) services those can only be documented after the State has documented that state plan-generated savings are enough to pay for the 1915(b)(3) Costs. Trend for 1915(b)(3) services in the initial waiver can be no greater than State Plan service trend (because there is no historic 1915(b)(3) service trend rate) as noted in the adjustments section.

The State must separately document Medical Assistance service expenditures and State administrative costs related to those services. Case management fees paid to providers in a PCCM program should be included as Medical Assistance service expenditures.

A State may make changes to their Medicaid and/or Medicaid waiver programs (e.g., changes to covered services or eligibility groups) during the period of time covered by an existing waiver. When the State makes these changes and there is a cost impact, CMS will require States to submit amendments which will modify P1 and P2 of the existing waiver calculations. By amending the existing P1 and P2 the State will ensure that when the State does its subsequent Renewal Waiver the R1 and R2 actual expenditures do not exceed the previous waiver's P1 and P2 expenditures solely as a result of the change to the Medicaid and/or Medicaid waiver program.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY eligible member months (R2 if a renewal). *See the example spreadsheets.*

Step 3. List the weighted average PMPM calculated in **Appendix D3** for Initial, Conversion or Comprehensive Renewal waivers.

Expedited Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D. To calculate the PMPM by MEG, the State should divide the cost from Schedule D for R2 and by the R2 member months for each MEG. The State

should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts.

Step 4. In **Appendix D5**, list the program adjustments percentages and the monetary size of the adjustment by MEG as applicable for State Plan services. The State may then combine all adjustment factors which affect a given MEG, and apply the adjustments accordingly. The derivation of a combined adjustment factor must be explained and documented.

Note adjustments in different formats as necessary. *See the Nebraska example spreadsheet as an example only. Some adjustments may be additive and others may be multiplicative. Please use the appropriate formula for the State's method.*

Step 5. Compute the PMPM projection by MEG by adding the service, incentive, administration, and 1915(b)(3) costs and the effect of all adjustments. These amounts need to be reflected in the State's next waiver renewal. These amounts represent the final PMPM amounts that will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes among MEGs when submitting their next waiver renewal cost-effectiveness calculations. In the subsequent renewal, the State should have PMPM Actual Waiver costs for each MEG for the 2-year period equal to or less than these Projected PMPM Waiver Costs for each MEG.

Appendix D6 – RO Targets

For the purpose of on-going quarterly monitoring in the future period, the State must document total cost and PMPM cost projections for RO use. The ROs will be using a two-fold test: one that monitors for overall growth in waiver costs on the CMS-64 forms and another that monitors for PMPM waiver cost-effectiveness. The State projections for RO use in both tests are in Appendix D6.

The first test projects quarterly aggregate expenditures by MEG for RO use in monitoring CMS 64.9 Waiver, CMS 64.21U Waiver, and CMS 64.10 Waiver expenditures during the upcoming waiver period. On a quarterly basis, CMS will compare aggregate expenditures reported by the State on CMS-64 Waiver forms to the State's projected expenditures (P1 and P2) included in the State's cost-effectiveness calculations as a part of the quarterly CMS-64 certification process. As part of the waiver submission, the State must calculate and document the projected quarterly aggregate Medical Assistance services and State administrative expenditures for the upcoming period. This projection is for the population covered under the waiver and will assist RO financial staff in monitoring the total waiver spending on an on-going basis.

The second test projects quarterly PMPM expenditures by MEG for RO use in monitoring waiver cost-effectiveness in the future waiver period. Because states are required to demonstrate cost-effectiveness in the historical two-year period of each Renewal Waiver, CMS intends to monitor State expenditures on an ongoing basis using

the State's CMS-64 Waiver submissions. CMS will determine if the State's quarterly CMS-64 Waiver submissions support the State's ability to demonstrate cost-effectiveness when the State performs its Renewal Waiver calculations. For the second test, States are not held accountable for caseload increases. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State must submit member month data corresponding to the quarterly submission of the CMS-64 on an on-going basis. The State should ensure that the member month data submitted on an on-going basis is comparable to the member month data used to prepare the P1 and P2 member month projections. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months**.

Step 2. List the P1 and P2 projected member months by quarter for the future period.

Step 3. List the P1 and P2 MEG PMPM cost projections from **Appendix D5**. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State will calculate the weighted average PMPM with Casemix for P1 and P2 (respectively).

Renewal P1	Renewal P2
$\frac{\text{P1 PMPM Costs x P1 MM}}{\text{P1 MM}}$	$\frac{\text{P2 PMPM Costs x P2 MM}}{\text{P2 MM}}$
Casemix for P1	Casemix for P2

The State is calculating the PMPM with Casemix for P1 and P2 so that the Region can compare the projected PMPMs to the actual PMPMs for administration (the State is calculating all of the PMPMs but only the administration PMPM will be used in Appendix D6). Administration is an area of risk for States in a 1915(b) waiver. If a State does not enroll enough persons into the program to offset high fixed administration costs, the State is at risk for not being cost-effective over the two year period. The Region will use this particular weighted PMPM to monitor State enrollment levels to ensure that high administrative costs are more than offset on an on-going basis.

Step 4. Multiply the quarterly member month projections by the P1 and P2 PMPM projections to obtain quarterly waiver aggregate targets for the waiver. *See the example spreadsheets.*

For the first aggregate spending test, the State will use the MEG PMPM from Appendix D5 multiplied by the projected member months to obtain the aggregate spending. The MEG PMPM from Appendix D5 is the number that States will be held accountable to in their waiver renewal. However, States will not be held accountable to the projected

member months in their waiver renewal. For this reason, a second test modifying the demographics to reflect actual caseload is necessary.

			Q1 Quarterly Projected Costs		
Medicaid Eligibility Group (MEG)	**Total PMPM Admini-stration Cost Projection**	**Total PMPM Projected Service Costs**	**Member Months Projections**	**64.9W /64.21U W Service Costs include incentives**	**64.10 Waiver Admini-stration Costs**
MCHIP - MCO/PCCM/ PIHP (3 co.)	$ 10.00	$ 192.90	81	$ 15,624.75	$ 810.39
MCHIP - PIHP statewide	$ 0.86	$ 21.20	28,821	$ 611,004.39	$ 24,866.56
Title XIX MCO/PCCM/ PIHP (3 co)	$ 47.33	$ 954.89	15,981	$ 15,260,090.40	$ 756,396.07
Title XIX - PIHP statewide	$ 2.37	$ 48.20	444,217	$ 21,409,496.79	$ 1,051,238.55
Total			**489,100**	**$ 37,296,216.33**	**$ 1,833,311.56**
Weighted Average PMPM Casemix for P1 (P1 MMs)	**$ 3.77**				

Step 5. Create a separate page that documents by quarter Form 64.9 Waiver, Form 64.21U Waiver, and Form 64.10 Waiver costs separately for ease of RO CMS-64 monitoring. *See the example spreadsheets.*

Example:

Projected Year 1 - July 1, 2002 - June 30, 2003

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Start 7/1/2002
64.21U Waiver Form	MCHIP - MCO/PCCM/PIHP (3 co)	$ 15,624.75
64.21U Waiver Form	MCHIP - PIHP statewide	$ 611,004.39
64.9 Waiver Form	Title XIX - MCO/PCCM/PIHP (3 co)	$ 15,260,090.40

64.9 Waiver Form	Title XIX - PIHP statewide	$ 21,409,496.79
64.10 Waiver Form	All MEGS	$ 1,833,311.56

Step 6. Create a separate page that documents by quarter PMPM MEG costs separately for each of RO monitoring. Please include space for RO staff to list actual member months and aggregate totals by quarter. Please include formulas for RO staff to calculate actual PMPMs by quarter for comparison to projections. *See the example spreadsheets.*

For the second test, the State will carry forward the P1 (and P2 respectively) MEG PMPM services costs and the weighted average PMPM administration costs Casemix for P1 (and P2 respectively).

Divide the actual aggregate costs by the actual aggregate member months (MM) to get PMPM actual costs**.** The State will divide the costs of the program by the caseload for the same quarter from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each quarter of the waiver. In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

On-going Actual P1 Q1	On-going Actual P2 Q5
P1 Q1 Actual Costs / P1 Q1 Actual MM	P2 Q5 Actual Costs / P2 Q5 Actual MM
Casemix for P1 Q1 actual	Casemix for P2 Q5 actual

On an on-going basis, the State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms. The RO analyst will enter the member month and CMS-64 form totals into the worksheet, which will calculate the actual MEG PMPM costs. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected PMPM expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions.

Example

Waiver Form	**Medicaid Eligibility Group (MEG)**	**State Completion Section - For Waiver Submission**	**RO Completion Section - For ongoing monitoring**		
			Q1 Quarterly Actual Costs		
		P1 Projected PMPM From Column I (services)	**Member Months Actuals**	**Actual Aggregate**	**Actual PMPM Costs**

		From Column G (Administration)	Start 7/1/2002	Waiver Form Costs	
64.21U Waiver Form	MCHIP - MCO/PCCM /PIHP (3 co.)	**$ 192.90**			#DIV/0!
64.21U Waiver Form	MCHIP - PIHP statewide	**$ 21.20**			#DIV/0!
64.9 Waiver Form	Title XIX - MCO/PCCM /PIHP (3 co)	**$ 954.89**			#DIV/0!
64.9 Waiver Form	Title XIX - PIHP statewide	**$ 48.20**			#DIV/0!
64.10 Waiver Form	All MEGS	**$ 3.77**			#DIV/0!

Appendix D7 - Summary

Document the State's overall cost-effectiveness analysis by waiver year.

In a renewal analysis, the State must clearly demonstrate that the PMPM actual waiver expenditures did not exceed the projected PMPM waiver expenditures for the population covered by the waiver. *For example, suppose a State's Initial Waiver (ST 01) considered years 2003 and 2004 to be P1 and P2 respectively. In the subsequent Renewal Waiver (ST 01.R01), the State's R1 and R2 will also be years 2003 and 2004, respectively. The State must demonstrate that in total the actual expenditures in the current Renewal Waiver's R1 and R2 (2003 and 2004) did not exceed the total projected expenditures in the Initial Waiver's P1 and P2 (2003 and 2004). Taking the example above, a State would use the actual expenditures from 2003 and 2004 as the basis for projecting expenditures for the renewal waiver period 2005-2006 (P1 and P2 respectively). In the second Renewal Waiver (ST 01.R02), the actual expenditures in the renewal period for 2005-2006 (R1 and R2) must be less than the expenditures for 2005-2006 (P1 and P2) projected in the previous renewal (ST 01.R01). For each subsequent renewal, the State will compare actual expenditures in R1 and R2 to the projected P1 and P2 values from the previously submitted Renewal Waiver.*

Cost-effectiveness will be determined based on the sum of Medical Assistance service expenditures and State administrative costs on a PMPM for the two-year period. In this instance, the weighted PMPM for both the projection and the actual cost is based on the Casemix for actual enrollment in R1 and R2. In this way, the State is not held accountable for any caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY (R1 and R2 if a renewal), P1 and P2 annual projected member months.

Step 3. List the BY (R1 and R2 if a renewal), P1 and P2 PMPM projections from **Appendix D5**.

List and calculate the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the PMPM for that year's demographics and for the previous year's demographics so that CMS can compare the PMPM for the enrolled caseload to the PMPM holding the caseload's demographics constant. In short, the new PMPM times the old MM (new dollars times old weights = Casemix effect for old MM) is the Casemix for the old MM.

Initial or Conversion Waiver

Year	Calculation	Where Already Calculated	Formula
BY	BY Overall PMPM for BY (BY MMs)	Appendix D3	$\frac{\text{BY Aggregate Costs}}{\text{BY MM}}$
P1	P1 Weighted Average PMPM Casemix for BY (BY MMs) P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	Appendix D6	$\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs) P2 Weighted Average PMPM Casemix for BY (BY MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6 Appendix D6	$\frac{\text{P2 PMPM x P1 MM}}{\text{P1 MM}}$ $\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$ $\frac{\text{P2 PMPM x BY MM}}{\text{BY MM}}$ $\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$

Renewal Waiver

Year	Calculation	Where Already Calculated	Formula
R1	R1 Overall PMPM for R1 (R1 MMs)	Appendix D3	$\frac{\text{R1 Aggregate Costs}}{\text{R1 MM}}$
R2	R2 Weighted Average PMPM Casemix for R1 (R1 MMs) R2 Overall PMPM for R2 (R2 MMs)	Appendix D3	$\frac{\text{R2 PMPM x R1 MM}}{\text{R1 MM}}$ $\frac{\text{R2 Aggregate Costs}}{\text{R2 MM}}$
P1	P1 Weighted Average PMPM Casemix for R2 (R2 MMs)		$\frac{\text{P1 PMPM x R2 MM}}{\text{R2 MM}}$

	P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	Appendix D6	P1 PMPM x P1 MM / P1 MM
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs)		P2 PMPM x P1 MM / P1 MM
	P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6	P2 PMPM x P2 MM / P2 MM
	P2 Weighted Average PMPM Casemix for R1 (R1 MMs)		P2 PMPM x R1 MM / R1 MM
	P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6	P2 PMPM x P2 MM / P2 MM

Step 4. Calculate a total cost per waiver year. Multiply BY MM by BY PMPM. (Renewal Waiver, multiply R1 MM by R1 PMPM and multiply R2 MM by R2 PMPM) Multiply P1 MM by P1 PMPM. Multiply P2 MM by P2 PMPM. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

Step 5. Renewal Waiver only - Calculate the Total Previous Waiver Period Expenditures (Casemix for R1 and R2). *Note: the Total Cost per Waiver for R1 should match the Schedule D submitted. No portion of R2 should be projected in order to timely submit the waiver renewal application.* Instead, the State should use data from the Schedule D and complete the number of months of data used in Appendix D7.

Step 6. Calculate the Total Projected Waiver Expenditures for P1 and P2.

Step 7. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.
The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training and States should pay particular attention to this detail.***

On Appendix D7, the State will need to enter the number of months of data in each BY (for an initial and conversion waiver) and R1 and R2 (for a renewal waiver). The State will also need to enter the number of months it is projecting in P1 and P2 (typically 12 months in both P1 and P2). If there is a gap of time between the BY/R2 and P1 and P2, the State will also need to enter the number of months in the "gap".

Example 1: Renewal with less than 2 years of data in R2
R1 - State Fiscal Year 2001 (July 1, 2000 to June 30, 2001)
R2 - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2003 (July 1, 2002 to June 30, 2003)
P2 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)

The State wants to submit its renewal on May 1, 2002, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2002. The State then has less than two full years of R1 & R2, in this instance 12 months of R1 but only 9 months of R2:

1. The State enters the number of months for R1, R2, P1, and P2 in the spreadsheet in Appendix D7.

NUMBER OF MONTHS OF DATA		
	R1	12
	R2	9
	Gap (end of R2 to P1)	3
	P1	12
	P2	12
	TOTAL	48
	(Months-12)	36

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

Overall R1 to P2 Change (monthly)	Overall R1 to P2 Change (annualized)
0.4%	**5.5%**
0.5%	**5.6%**
0.5%	**5.6%**
0.5%	**6.5%**

0.5%	**6.1%**
0.6%	**7.4%**

Example 2: Conversion with a lag between BY and P1
BY - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)
P2 - State Fiscal Year 2005 (July 1, 2004 to June 30, 2005)

The State wants to submit its renewal on May 1, 2003, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2003. The State then has a full year of BY but a lag between BY and P1 of 12 months:

1. The State enters the number of months for BY, gap, P1, and P2 in the spreadsheet in Appendix D7.

NUMBER OF MONTHS OF DATA	
BY	12
Gap (end of BY to P1)	12
P1	12
P2	12
TOTAL	48
(Months-12)	36

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

Overall BY to P2 Change (monthly)	Overall BY to P2 Change (annualized)
0.7%	**8.8%**
0.6%	**6.9%**
0.7%	**8.6%**
0.8%	**10.1%**
0.8%	**9.4%**
0.9%	**11.5%**

Step 7. Calculate the annual percentage change. For Initial and Conversion waivers, calculate the percentage change from BY to P1, P1 to P2 and BY to P2 for each MEG. For renewals, calculate the percentage change from R1 to R2, R2 to P1, P1 to P2, and R1 to P2 for each MEG. Calculate the annual percentage change for the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the annual percentage change in the PMPM compared to the previous year for that year's demographics and for the previous year's demographics. This allows CMS to compare the percentage of the PMPM that changed due to the caseload's demographics changes. The sample spreadsheets have appropriate formulas for State use. Explain these percentage changes in the State Completion section.

Step 8. Renewal Waiver only - list the PMPM cost projections (P1 and P2) by MEG from the previous waiver submittal.

Step 9. Renewal Waiver only - Calculate the Actual Previous Waiver Period Expenditures, Total Projection of Previous Waiver Period Expenditures, and Total Difference between Projections and Actual Waiver Cost for the Previous Waiver using actual R1 and R2 member months. Using actual R1 and R2 member months will hold the State harmless for caseload changes. Multiply the PMPM projections by the actual R1

and R2 member months to obtain the overall expenditures for the past Waiver Period. Subtract waiver actual waiver costs for R1 and R2 from the projected PMPM program costs previously submitted (P1 and P2 in the previous waiver submission) to obtain the difference between the Projections and Actual Waiver Cost for the retrospective period. If **Actual Waiver Service Cost plus the Actual Waiver Administration Cost is less than or equal to Projected Waiver Cost,** then the State has met the Cost-effectiveness test and the waiver may be renewed.