Facesheet: 1. Request Information (1 of 2)

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

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
Family Care	Family Care	PIHP;	
Partnership	Family Care Partnership	MCO;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):

B Waiver Renewal - Family Care and Family Care Partnership 2025

C. Type of Request. This is an:

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

The amendment modifies (Sect/Part):

This waiver amends cost projections of the Family Care and Family Care Partnership programs. The changes are limited to Section D and a new workbook for the cost projections.

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

- ○ **1 year**
- ○ **2 years**
- ○ **3 years**
- ○ **4 years**
- ◉ **5 years**

Draft ID:WI.048.08.02
Waiver Number:WI.0007.R08.01

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Approved Effective Date of Base Waiver being Amended: 01/01/25

Proposed Effective Date: (mm/dd/yy)

01/01/25

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

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

Name:

Kelly Van Sicklen

Phone: (608) 267-0243 **Ext:** ☐ **TTY**

Fax:

E-mail:

kelly.vansicklen@dhs.wisconsin.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☒ **Family Care**

Name:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

☒ **Family Care Partnership**

Name:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

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

The SMA presented information about the waiver amendment at the Tribal Health Director?s meeting on September 17, 2025 to solicit input of the waiver. The SMA also provided an opportunity to comment on the waiver changes after the meeting. The SMA received one question related to general program operations.

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).

Implementation of the Family Care program began in 1998 to reform the existing fragmented long-term care system in Wisconsin. The first members were enrolled in the managed long-term services and supports program in February of 2000. For several years, Family Care operated as a pilot program in five counties serving frail elders and adults with physical and intellectual and/or developmental disabilities.

With the assistance of a Real Choice Systems Change grant awarded in September 2004, Wisconsin began to expand Family Care geographically beyond the five pilot counties. In early 2007, the first expansion counties began operating. By February 2014, Family Care had expanded to 57 of Wisconsin?s 72 counties and waitlists were eliminated in these counties. Family Care became statewide with expansion to the remaining counties by 2018.

On 7/1/18, enrollment in a PIHP became mandatory for the Family Care program. This was a technical change. Enrollment in a PIHP has always been a requirement in Family Care. The SMA has always contracted with PIHPs to administer the program. These PIHPs are certified by the SMA and monitored under a comprehensive SMA-PIHP contract. All individuals are able to opt out of the Family Care program at any time.

On 7/1/18, the SMA established non-risk payments to PIHPs for Indian members receiving care management services from Indian Health Care Providers (IHCPs).

On 1/1/2025, the Family Care Partnership program, an Managed Care Organization (MCO) program, is added to this 1915(b) waiver. In instances throughout the waiver where PIHP is mentioned, as of 1/1/25 MCO is also included.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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

   a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
   -- *Specify Program Instance(s) applicable to this authority*

   ☒ **Family Care**

   ☒ **Partnership**

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

   ☒ **Family Care**

   ☒ **Partnership**

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

   ☐ **Family Care**

   ☐ **Partnership**

   d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

-- *Specify Program Instance(s) applicable to this authority*

☒ **Family Care**

☒ **Partnership**

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

☒ **MCO**

☒ **PIHP**

☐ **PAHP**

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

☐ **FFS** Selective Contracting program
Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

   a. ☒ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **Family Care**

   ☒ **Partnership**

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

   ☒ **Family Care**

   ☒ **Partnership**

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

   ☒ **Family Care**

   ☒ **Partnership**

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

In certain counties, dependent on RFP results, successful certification and contracting with PIHPs and MCOs, Family Care and Family Care Partnership members may only have one PIHP or MCO option.

-- Specify Program Instance(s) applicable to this statute

☒ **Family Care**

☒ **Partnership**

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

-- Specify Program Instance(s) applicable to this statute

☐ **Family Care**

☐ **Partnership**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

◉ **The PIHP is paid on a risk basis**

○ **The PIHP is paid on a non-risk basis**

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

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

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

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

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

The PIHPs will not be at financial risk for Indian members choosing to receive care management from an Indian Health Care Provider (IHCP). The SMA will pay the PIHPs an interim monthly payment. The SMA will reconcile the interim payment so that the PIHP receives the difference between the total non-administrative portion of the interim payments the SMA paid the PIHP before the member?s cost share was deducted and the full cost of services the PIHP paid for Indian members receiving care management from an IHCP. The SMA will determine the full cost of services to be reconciled by totaling all encounters the PIHP submitted to the SMA for Indian members receiving care management from the IHCP. The reconciliation will take place annually within eighteen months of the calendar year in which the Indian member received services. The reconciliation could include recoupments from the PIHPs if actual service costs are less than the payments they received from the SMA.
The administrative portion of the interim payments the SMA pays to the PIHP will be developed in accordance with the administrative rate methodology the SMA uses to develop the PIHP?s capitation payment for other populations.
The SMA will submit claims for 100% federal financial participation for payments to PIHPs only for Indian members receiving care management through the IHCP and only for those services provided by an IHCP.
The SMA may choose to pay the PIHPs an interim payment equal to the PIHP?s capitation payment for other populations. The SMA acknowledges that the cost data from the non-risk contract must be excluded from the data used to develop the capitation rates for the at-risk contracts.
The SMA will not need to establish a rate schedule for the 1915(c) waiver services within the PIHP contract. PIHPs and IHCPs can negotiate the rates the PIHP will pay as the interim payment to the IHCPs.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

☒ **Procurement for MCO**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)

- ○ **Sole source** procurement
- ○ **Other** (please describe)

☒ **Procurement for PIHP**

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

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

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

☐ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries? ability to access services.

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

Program: " **Family Care.** *"*

☐ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☒ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**
please describe

.

Program: " **Family Care Partnership.** *"*

☐ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☒ **Other:**
please describe

In most counties, members will have a choice two or more MCOs. In all counties where Partnership is offered, members are able to select Family Care and receive their acute/primary Medicaid services on a fee-for-service basis.

Enrollees are offered the choice of the Partnership MCO or the PIHP/FFS for Family Care. Enrollment option counseling for all Partnership enrollees is done through the Aging and Disability Center (ADRC). ADRCs provide counseling about options available to meet long-term care needs as well as factors to consider in making long-term care decisions. Options counseling is a person-centered, interactive decision-support process. The information provided during options counseling must be timely, accurate, thorough, unbiased, and appropriate to the customer's situation. Long-term care options counseling is tailored to the needs of the customer and does not attempt to persuade the customer to choose any particular long-term care setting, program, or service. Options counseling does not exclude information about any suitable option, program, or provider. Accordingly, in any county with one Partnership MCO, the enrollee will be informed of the alternative choice of PIHP/FFS Family Care.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

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

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

○ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

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

Additional Information. Please enter any additional information not included in previous pages:

Members eligible only for State Plan services, because they do not meet the level of care requirements for 1915 (c) waiver services, have the choice of receiving those Medicaid State Plan services through the PIHP or disenrolling and receiving state plan services through regular Medicaid if they financially qualify.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*

     ☒ **Family Care**

     ☐ **Partnership**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☐ **Family Care**

     ☒ **Partnership**
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)
https://www.dhs.wisconsin.gov/publications/p01790.pdf	PIHP	Inclusa
https://www.dhs.wisconsin.gov/publications/p01790.pdf	PIHP	Lakeland Care
https://www.dhs.wisconsin.gov/publications/p01790.pdf	PIHP	Community Care, Inc
https://www.dhs.wisconsin.gov/publications/p01790.pdf	PIHP	MyChoice Wisconsin
https://www.dhs.wisconsin.gov/publications/p01789.pdf	MCO	MyChoice Wisconsin
https://www.dhs.wisconsin.gov/publications/p01789.pdf	MCO	Community Care, Inc.
https://www.dhs.wisconsin.gov/publications/p01789.pdf	MCO	iCare

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

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

   ○ **Mandatory enrollment**

○ **Voluntary enrollment**

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

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

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

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

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

○ **Mandatory enrollment**

○ **Voluntary enrollment**

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

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

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

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

☒ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children?s Health Insurance Program (SCHIP) through the Medicaid program.

◉ **Mandatory enrollment**

○ **Voluntary enrollment**

☒ **Other** (Please define):

All persons aged 18 or older who are eligible for any mandatory or optional full-benefit group under the state plan with a physical disability, developmental disability, or are frail elders, and who are determined through functional screening to require a nursing home or non-nursing level of care are included.

Childless adults covered under Wisconsin?s Section 1115(a) waiver with a physical disability, developmental disability, or are frail elders and who are determined through functional screening to require a nursing home or non-nursing level of care are included.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. Excluded Populations. Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the ?Aged? population may be required to enroll into the program, but ?Dual

Eligibles? within that population may not be allowed to participate. In addition, ?Section 1931 Children? may be able to enroll voluntarily in a managed care program, but ?Foster Care Children? within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

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

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

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

☐ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

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

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

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

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

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

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

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

☒ **Other** (Please define):

? Persons who are only eligible only for family planning services
? Persons who are only eligible for TB-related services
? Persons who are only eligible for emergency services
? Persons under age 18.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

1) Included Populations: Section 1931 Adults and Related Populations -
Only the subset of adults in this population with disabilities who are determined through functional screening to require a nursing home or non-nursing level of care are included.

2) Excluded Populations: Participate in HCBS Waiver -
Medicaid beneficiaries who participate in a different Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver) are excluded, except for the 1915(c) HCBS waiver (CMS control number WI.0367)that runs concurrently with this 1915(b) waiver.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

☒ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

   Emergency Services Category General Comments (optional):

   Inpatient and outpatient services needed to evaluate or stabilize an emergency condition are not a covered benefit in Family Care PIHPs. Emergency services are covered by the Medicaid State Plan available fee for service. PIHPs are responsible to instruct all members on where and how to obtain emergency services not covered in the PIHP benefit package. In addition, PIHP interdisciplinary care management teams are responsible to monitor the health conditions of members and to coordinate PIHP services with primary and acute health care services members receive from other sources. This includes responsibility for referring to, or arranging for, emergency services when necessary and ensuring the availability of transportation needed to access primary and acute health care services. PIHP member handbooks are required to explain that members should access emergency medical care as they would in any case, such as by calling 911.
   Partnership MCOs cover emergency services, without prior authorization, even if the emergency services provider does not have a contract with the MCO.

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

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

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

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

   ☐ Other (please explain):

   ☒ Family planning services are not included under the waiver.

   Family Planning Services Category General Comments (optional):

   Family planning services are not included in the Family Care PIHP benefit package. Family planning services are covered by the Medicaid State Plan available fee for service.

   Partnership MCOs are required to cover family planning services, whether provided by network or out-of-network providers. If the enrollee selects an out-of-network provider, the MCO will reimburse family planning service provider according to the Wisconsin Medicaid fee for service rates and rules.

Part I: Program Overview

F. Services (3 of 5)

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

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

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

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

FQHC Services Category General Comments (optional):

FQHC services are not included in the Family Care or Family Care Partnership benefit. A member may obtain FQHC services through the regular Medicaid Program while enrolled in this waiver program.

For Indians choosing to receive Family Care services from an Indian Health Care Provider (FQHC)under ARRA, those services, per CMS, are considered long-term care services and not FQHC services.

5. EPSDT Requirements.

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

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

1. Assurances for MCO, PIHP, or PAHP programs

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The State?s PCCM Program includes established standards for in-office waiting

times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the State?s standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State?s standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

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

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

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

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☒ 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:

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

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

The following items are required.

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

Please provide justification for this determination:

Wisconsin does not separately define Family Care or Partnership members with special health care needs because all Family Care and Partnership members require LTSS. The Family Care PIHPs meet the exception in 42 CFR 438.208(a)(2) and the Partnership MCOs meet the exception in 42 CFR 438.208(a)(3).

The members served in this waiver program are limited to those who are a frail elder, individuals with an intellectual disability, or physical disability who requires LTSS to remain in the community. Family Care and Partnership members have access to all of the 1915(c) waiver services. Partnership includes dually eligible members and also covers primary health care services for both acute and chronic conditions. Accordingly, the SMA has determined that identification of members with special health care needs for additional services is not necessary.

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

Please describe:

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

Please describe the enrollment limits and how each is determined:

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

1. ☐ Developed by enrollees? primary care provider with enrollee participation, and in consultation with any specialists? care for the enrollee.
2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. ☐ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee?s condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

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

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee?s needs.
b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee?s overall health care.
c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
e. ☐ There is appropriate and confidential **exchange of information** among providers.
f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager?s files.

i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

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

☒ 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: 06/26/18 (mm/dd/yy)

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

Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	MetaStar, Inc.		Validation of Performance Improvement Projects Performance Measure Validation Information Systems Capabilities Assessment Provider Network Adequacy MetaStar performs the 3 year review to determine MCO compliance with EQR activities identified in 42 CFR 438.358	Care Management Review
PIHP	MetaStar, Inc.	X		Care Management Review

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
			Validation of Performance Improvement Projects Performance Measure Validation Information Systems Capabilities Assessment Provider Network Adequacy MetaStar performs the 3 year review to determine PIHP compliance with EQR activities identified in 42 CFR 438.358	

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCM?s response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to State?s medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollee?s PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

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

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

   Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☒ 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:

Indirect marketing materials include internet, brochures and leaflets, radio, television and print media presentations and materials in all mediums to individuals who are not currently enrolled in any of Wisconsin?s long-term support programs. Pursuant to the SMA-PIHP and SMA-MCO Contract, all marketing/outreach materials must be approved by the SMA prior to distribution.

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

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

1. ☒ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

Enrollment is conducted by Aging and Disability Resource Centers (ADRCs), which are independent from the PIHPs. ADRCs monitor for any potential gifts or incentives by the PIHPs. The SMA requires ADRCs to use SMA-approved materials in the enrollment process and choice counseling.

The SMA-PIHP contract also prohibits PIHPs from offering potential members any material or financial gain as an enrollment incentive and requires that all PIHP marketing/ outreach activities and materials be approved by the SMA.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☐ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

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

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☐ The languages comprise all languages in the service area spoken by approximately [ ] percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Marketing plans must be submitted for initial certification and during annual certification if there has been a material change since last approved by the SMA.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ 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:

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

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

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

The SMA determines the non-English languages prevalent in each service area using the methodology described below.

Arabic, Chinese Mandarin, Hmong, Laotian, Serbo-Croatian, Somali, Spanish

If the State does not translate or require the translation of marketing materials, please explain:

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

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines ?significant.?:

b. ☐ The languages spoken by approximately ____ percent or more of the potential enrollee/enrollee population.

c. ☒ Other

Please explain:

Using member eligibility data confirmed with United States Census Bureau survey data, the SMA determines which non-English languages prevalent in each service area. Prevalent languages are any non-English languages spoken by 1% or more of the population or the three most commonly spoken non-English languages, whichever is greater.

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

PIHPs, Aging and Disability Resource Centers (ADRCs), and Tribal ADRSs are required to contract with live oral interpreters for prevalent non-English languages. A telephonic translation service is available for other non-prevalent languages. The MCO must provide 24 hour a day 7 days a week access to interpreters conversant in languages spoken by members in the MCO.

3. ☒ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The Aging and Disability Resource Center (ADRC) or Tribal ADRC helps potential enrollees understand managed care and the Family Care and Family Care Partnership programs, in particular. Enrollment counseling provided by the ADRC or Tribal ADRS provides information for prospective members to choose among the available managed long-term care options.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State

☒ Contractor

Please specify:

The SMA contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential enrollees.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as described by Wis. Admin. Code § DHS 10.22 and 42 CFR § 438.810(b)(1) and (2).

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

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

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

☐ the State

☒ State contractor

Please specify:

The SMA contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential enrollees.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as described by Wis. Admin. Code § DHS 10.22 and 42 CFR § 438.810(b)(1) and (2).

☒ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

PIHPs and MCOs are required by contract to provide information about member rights to enrollees.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

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

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The SMA contracts with Aging and Disability Resource Centers (ADRCs) in each service area to serve as the single entry point for information and assistance on long-term care and other issues affecting older people, people with disabilities, or their families. ADRCs provide (1) information and education, (2) outreach, (3) assistance, (4) benefit specialist services, (5) long-term care options counseling and referral to appropriate LTC programs or providers, (6) Family Care functional eligibility determination and level of care assessments using the SMA-developed automated long-term care functional screening tool, and (7) coordination of the Family Care eligibility and enrollment processes. For Indians, the Tribal Aging and Disability Resource Specialist (TADRS) performs the functional screen when the individual?s tribe has opted to provide this service to its members. The TADRS is certified to provide the screen, and the individual opts to have this service provided by the TADRS rather than the ADRC.

The functional screen process must include a face-to-face interview with the individual and/or his/her legal representative. The ADRC or TADRS is required by contract to provide information of available service and enrollment options, including but not limited to home care, community services, residential care, nursing home care, post hospital care, and case management services. The ADRC or TADRS is also required to document the options discussed, factors considered, results, and next steps.

If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP), if available, and the PIHP for care management services and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. The ADRC or TADRS also provides information about other options available to individuals, including the SSI Managed Care Program, where available.

If the individual chooses Family Care or Family Care Partnership, the preferred enrollment date is identified. This information is documented on an enrollment form, which is signed by the member or his/her legal representative. The ADRC or TADRS facilitates enrollment and provides the member and the PIHP or MCO with copies of the signed enrollment form. The enrollment form is maintained by the ADRC or TADRS.

In addition, once enrolled in managed long term care, the plan of care used by each PIHP includes a statement that informs the individual of the options for nursing facility services, self-directed supports waiver services, home and community-based waiver services, IHCP services available to Indians, and the availability of options counseling regarding these services at the ADRC or TADRS. An individual can request nursing facility services as part of the individualized member-centered care planning process in the PIHP, or the individual may disenroll at any time to seek admission and Medicaid reimbursement for nursing facility care or to seek self-directed supports program services.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

☒ 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: Aging and Disability Resource Centers

Please list the functions that the contractor will perform:

☒ choice counseling

☒ enrollment

☒ other

Please describe:

Aging and Disability Resource Centers (ADRCs) provide choice counseling to those who are functionally eligible for or considering enrolling in long-term care. The counseling sessions help prospective members weigh their long-term care options and select a program. When a prospective member decides to enroll in long-term care, the ADRC obtains the required enrollment forms and processes the enrollment.

In addition to the functions listed above, ADRCs administer the long-term care functional screen to determine whether an individual is eligible for the program; provide options counseling to inform prospective members of the full range of care options available; and conduct disenrollment counseling to discuss the reasons for disenrollment, programs and services that maybe available to the member if he or she disenrolls, and the implications of disenrollment.

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

☐ This is a **new** program.

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

☒ This is an **existing program** that will be expanded during the renewal period.

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

Family Care will not be expanded during the renewal period.
Family Care Partnership may be expanded to additional counties during the waiver period. The expansion would be phased in by area, based on procurement schedules and results.

☐ 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

☐ ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

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

☐ The State automatically enrolls beneficiaries.

☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

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

☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

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

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

i. ☒ Enrollee submits request to State.

ii. ☒ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or

refer it to the State. The entity may not disapprove the request.

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

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

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of [ ] months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

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

☒ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. ☒ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

Enrollees are permitted to disenroll from the PIHP, or transfer to another PIHP, without cause at any time.

The PIHP can request enrollee reassignment for the following reasons:

If the member has committed acts or threatened to commit acts that pose a threat to PIHP staff, subcontractors, providers, or other members of the PIHP; the PIHP is unable to assure the member?s health and safety because the member refuses to participate in care planning or to allow care management contacts, or; the member is temporarily out of the PIHP?s service area and the PIHP cannot establish a cost-effective care plan to support the member?s outcomes during the absence and the PIHP is unable to assure the member?s health and safety during the period of absence; or the member is no longer accepting services, other than care management efforts to contact the member.

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

If a member speaks with the PIHP regarding disenrollment, the PIHP must direct the member to the ADRC. Once the member makes contacts the ADRC, the ADRC will provide options counseling. If the member wishes to disenroll, the member (or his/her legal decision-maker) will sign a disenrollment form and the ADRC will inform the PIHP of the disenrollment and enter the information into the SMA?s enrollment system. If applicable, the ADRC will also notify the newly selected PIHP of the enrollment and enrollment date. A member may disenroll at any time. The disenrollment date is chosen by the member. The ADRC will inform the member of any other long term care options available to the member

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

☒ 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.

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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

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

action,

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

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

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

b. Timeframes

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

☐ The State?s timeframe within which an enrollee must file a **grievance** is _____ days.

c. Special Needs

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

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

- ☐ the State
- ☐ the State?s contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

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

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

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

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

☐ Has time frames for resolving requests for review.

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

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

3. Employs or contracts directly or indirectly with an individual or entity that is

a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☒ 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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a ?big picture? of the monitoring activities, and that the State has at least one activity in place to monitor each of

the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under ?Evaluation of Program Impact.?
  - There must be at least one check mark in one of the three columns under ?Evaluation of Access.?
  - There must be at least one check mark in one of the three columns under ?Evaluation of Quality.?

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a ?big picture? of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:

- There must be at least one checkmark in each column under ?Evaluation of Program Impact.?
- There must be at least one check mark in one of the three columns under ?Evaluation of Access.?
- There must be at least one check mark in one of the three columns under ?Evaluation of Quality.?

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a ?big picture? of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under ?Evaluation of Program Impact.?
  - There must be at least one check mark in one of the three columns under ?Evaluation of Access.?
  - There must be at least one check mark in one of the three columns under ?Evaluation of Quality.?

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
Family Care	PIHP;
Partnership	MCO;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Family Care

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

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Responsible entity: SMA
Activity: The SMA develops a member satisfaction survey tool and contracts with a third party vendor to administer the survey. The SMA collects and analyzes the data.
Frequency: Annual
Information: The tool is designed to solicit member feedback about each PIHP's performance in offering choice, coverage, authorization, provider selection, and quality of care.

☐ **CAHPS**
Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Responsible entity: SMA
Activity: PIHPs report local grievance and appeal data to the SMA. The SMA collects data related to State-level appeals directed to the SMA and to the State Division of Hearings and Appeals; data is analyzed by SMA oversight teams for each PIHP and by SMA contract compliance staff.
Frequency: Data for individual PIHPs is analyzed quarterly by SMA oversight teams; statewide data is reviewed quarterly by SMA contract compliance staff.
Information: Data provides information on trends in grievances and appeals on individual PIHPs and collectively.

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

Responsible entity: SMA
Activity: The SMA provides a toll free number for members to report appeals or grievances to the SMA.
Frequency: Ongoing
Information: The entity contracted to monitor the hotline provides summary data to the SMA about appeals and grievances reported on the hotline.

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

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

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

Activity Details:

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

Activity Details:

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

Activity Details:

Responsible entity: SMA
Activity: Certification of PIHP network adequacy
Frequency: Annual
Information: PIHPs submit their complete provider network to the SMA for review. SMA oversight teams review the adequacy of the network through a process that includes review of historical service utilization data, current and projected plan enrollment, as well as provider availability per each region served.

k. ☒ **Ombudsman**

Activity Details:

Responsible entity: SMA
Activity: Monitor contracted ombudsman program's effectiveness in assisting members with grievances and appeals and identifying systemic grievance and appeal issues.
Frequency: Ongoing
Information: The contracted ombudsman program produces monthly, quarterly, and annual reports which are analyzed by the SMA. These reports provide data on appeal and grievance outcomes for members, the ombudsman's performance with respect to six key performance expectations, the results of an annual member satisfaction survey and any systemic grievance and appeal issues identified by the ombudsman.

l. ☒ **On-Site Review**

Activity Details:

Responsible entity: SMA and EQRO
Activity: Quality reviews
Frequency: Annual
Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievances, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

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

Activity Details:

Responsible entity: PIHP
Activity: PIHPs conduct two performance improvement projects (PIPs) per contract cycle. One PIP addresses clinical opportunities for improvement and the other addresses non-clinical opportunities for improvement. PIPs are reviewed by the SMA and validated by the EQRO annually.
Frequency: Biennial
Information: PIP activities and results are analyzed by the SMA and EQRO.

☒ **Clinical**

☒ **Non-clinical**

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

Activity Details:

Responsible entity: PIHPs, SMA, and EQRO
Activity: Care management review, quality compliance review, annual certification, performance measure validation, member survey, and National Core Indicators (please see http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/EQRO.htm). As part of the annual certification and the EQRO quality compliance review, the QAPIs of each PIHP are reviewed to ensure they include performance measures specified by the SMA. As part of the care management review performed by the EQRO, member care plans are reviewed for comprehensiveness and to ensure that they reflect things that are important to the member. The EQRO also validates performance measure data submitted by the PIHPs. The SMA supplements this information with data from the member survey, the Long-Term Care Functional Screen and the NCI to measure indicators related to community integration and quality of life.

COMMUNITY INTEGRATION
% of members who feel that their care plan supports the activities they want to do in their community, including visiting with family and friends, working, volunteering, etc.
? Source: 2018 Satisfaction Survey

% of people who have transportation when they want to do things outside their home (non-medical)
? Source: NCI AD and NCI IPS Surveys (note: this data is not available by PIHP)

QUALITY OF LIFE
% of people who feel the care supports and services they receive help them live a better life/meet all their needs
? Source: NCI AD and NCI IPS Surveys (note: this data is not available by PIHP)

% of members who are satisfied overall with their PIHP
? Source: 2018 Satisfaction Survey

% of members who report living in the setting they prefer
? Source: 2018 Adult LTC Functional Screen data

The SMA views its rebalancing results at an agency level across all programs. Measures include:

REBALANCING
% of total LTSS Medicaid funding spent on the care and support of enrollees in HCBS Waivers ? adults
? Source: 2017 LTC Scorecard (there is a lag on this data)

% of eligible Medicaid people enrolled in HCBS waivers ? adults
? Source: 2017 LTC Scorecard (there is a lag on this data)

% of elderly, blind, or disabled (EBD) Medicaid enrollees using nursing home care
? Source: 2017 LTC Scorecard (there is a lag on this data)

Frequency: Annual

Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievance, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☐ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

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

Activity Details:

q. ☒ **Provider Self-Report Data**

Activity Details:

Responsible entity: PIHP
Activity: PIHPs must verify their contracted providers are not excluded and must assure the SMA they do not knowingly employ or contract with excluded individuals or entities.
Frequency: Annual
Information: PIHPs must verify their contracted providers are not on the excluded provider registry.

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

t. ☐ **Other**

Activity Details:

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Family Care Partnership

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

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Responsible entity: SMA Activity: The SMA develops a member satisfaction survey tool and contracts with a third party vendor to administer the survey. The SMA collects and analyzes the data. Frequency: Annual Information: The tool is designed to solicit member feedback about each MCO's performance in offering choice, coverage, authorization, provider selection, and quality of care.

☐ **CAHPS**

Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Responsible entity: SMA Activity: MCOs report local grievance and appeal data to the SMA. The SMA collects data related to State-level appeals directed to the SMA and to the State Division of Hearings and Appeals; data is analyzed by SMA oversight teams for each PIHP and by SMA contract compliance staff. Frequency: Data for individual MCOs is analyzed quarterly by SMA oversight teams; statewide data is reviewed quarterly by SMA contract compliance staff. Information: Data provides information on trends in grievances and appeals on individual MCOs and collectively.

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

Responsible entity: SMA Activity: The SMA provides a toll free number for members to report appeals or grievances to the SMA. Frequency: Ongoing Information: The entity contracted to monitor the hotline provides summary data to the SMA about appeals and grievances reported on the hotline.

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

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

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

Activity Details:

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

Activity Details:

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

Activity Details:

Responsible entity: SMA Activity: Certification of MCO network adequacy Frequency: Annual Information: MCOs submit their complete provider network to the SMA for review. SMA oversight teams review the adequacy of the network through a process that includes review of historical service utilization data, current and projected plan enrollment, as well as provider availability per each region served.

k. ☒ **Ombudsman**

Activity Details:

Responsible entity: SMA Activity: Monitor contracted ombudsman program's effectiveness in assisting members with grievances and appeals and identifying systemic grievance and appeal issues. Frequency: Ongoing Information: The contracted ombudsman program produces monthly, quarterly, and annual reports which are analyzed by the SMA. These reports provide data on appeal and grievance outcomes for members, the ombudsman's performance with respect to six key performance expectations, the results of an annual member satisfaction survey and any systemic grievance and appeal issues identified by the ombudsman.

l. ☒ **On-Site Review**

Activity Details:

Responsible entity: SMA and EQRO Activity: Quality reviews Frequency: Annual Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievances, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

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

Activity Details:

Responsible entity: MCO Activity: MCOs conduct two performance improvement projects (PIPs) per contract cycle. One PIP addresses clinical opportunities for improvement and the other addresses non-clinical opportunities for improvement. PIPs are reviewed by the SMA and validated by the EQRO annually. Frequency: Biennial Information: PIP activities and results are analyzed by the SMA and EQRO.

☒ **Clinical**

☒ **Non-clinical**

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

Activity Details:

Responsible entity: MCOs, SMA, and EQRO Activity: Care management review, quality compliance review, annual certification, performance measure validation, member survey, and National Core Indicators (please see http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/EQRO.htm). As part of the annual certification and the EQRO quality compliance review, the QAPIs of each MCO are reviewed to ensure they include performance measures specified by the SMA. As part of the care management review performed by the EQRO, member care plans are reviewed for comprehensiveness and to ensure that they reflect things that are important to the member. The EQRO also validates performance measure data submitted by the MCOs. The SMA supplements this information with data from the member survey, the Long-Term Care Functional Screen and the NCI to measure indicators related to community integration and quality of life.

COMMUNITY INTEGRATION % of members who feel that their care plan supports the activities they want to do in their community, including visiting with family and friends, working, volunteering, etc. ? Source: 2018 Satisfaction Survey % of people who have transportation when they want to do things outside their home (non-medical) ? Source: NCI AD and NCI IPS Surveys (note: this data is not available by PIHP) QUALITY OF LIFE % of people who feel the care supports and services they receive help them live a better life/meet all their needs ? Source: NCI AD and NCI IPS Surveys (note: this data is not available by PIHP) % of members who are satisfied overall with their PIHP ? Source: 2018 Satisfaction Survey % of members who report living in the setting they prefer ? Source: 2018 Adult LTC Functional Screen data The SMA views its rebalancing results at an agency level across all programs. Measures include: REBALANCING % of total LTSS Medicaid funding spent on the care and support of enrollees in HCBS Waivers ? adults ? Source: 2017 LTC Scorecard (there is a lag on this data) % of eligible Medicaid people enrolled in HCBS waivers ? adults ? Source: 2017 LTC Scorecard (there is a lag on this data) % of elderly, blind, or disabled (EBD) Medicaid enrollees using nursing home care ? Source: 2017 LTC Scorecard (there is a lag on this data) Frequency: Annual Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievance, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☐ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

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

Activity Details:

q. ☒ **Provider Self-Report Data**

Activity Details:

Responsible entity: MCO Activity: MCOs must verify their contracted providers are not excluded and must assure the SMA they do not knowingly employ or contract with excluded individuals or entities. Frequency: Annual Information: MCOs must verify their contracted providers are not on the excluded provider registry.

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

t. ☐ **Other**

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

○ **This is the first time the State is using this waiver format to renew an existing waiver.**The State provides below the

results of the monitoring activities conducted during the previous waiver period.

◉ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

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.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

In 2018, the SMA and the UW Survey Research Center developed a survey that was administered by the Survey Center and sent to a sample of members with the goal of having responses at the 95% confidence level with a 5% margin by PIHP, program, and target group. The new survey tool includes similar questions to the earlier tool, but the Survey Center revised questions and response categories were revised to reflect best practice.

Data Analysis: Grievances and appeals numbers are small at the local and State level. Member appeals to the SMA and the State Division of Hearings and Appeals averaged 7/1000 members/month. Members may choose one or more of the following options to exercise their rights: PIHP level (required for initial review of both grievances and appeals); DHS review of plan grievance decisions; or State Fair Hearing for review of plan appeal decisions. State level data does not show problematic trends and the SMA did not identify trends or issues with local grievances and appeals.

Network Adequacy Assurance by Plan: The SMA annually reviews the adequacy of each PIHP?s network. PIHPs must have an electronic version of its provider network directory on its website. Directories are updated within 30 calendar days after the PIHP receives updated provider information. PIHP networks are assessed through a process that reviews historical service utilization data, current and projected plan enrollment, and provider availability per each region served. No significant issues were identified between 2022 and 2023.

Ombudsman: The responsible entity and activity described under section B, Part II, item k. is the SMA?s monitoring of the contracted ombudsman?s effectiveness in assisting members with appeals and grievances. PIHP performance regarding grievances and appeals is monitored as explained in section B, Part II, item d.

The SMA contracts with two outside entities to provide Ombudsman services to members ages 18-59 and members ages 60 and over. Both entities track internal data points relevant to their contract requirements and are able to produce quarterly, monthly or annual statistics to the SMA upon request.

The SMA identified no problems in the ombudsman?s effectiveness in assisting members with appeals and grievances.

Electronic Review: The EQRO does an electronic Annual Quality Review (AQR) of each PIHP. The AQR assesses the following PIHP systems and processes: Care Management Review, Assessment, Planning, Service Coordination and Delivery, Participant Centered Focus, Validation of Performance Improvement Projects, Quality Compliance Review, Member Rights, Access to Services, Structure and Operations, Quality Measurement and Improvement, and Grievance Systems. The AQR results are submitted to the SMA and can be found at: https://www.dhs.wisconsin.gov/familycare/statefedreqs/eqro.htm . Various issues were identified for each PIHP. The SMA required corrective actions, made improvement recommendations and monitored PIHP completion of requirements.

Performance Improvement Projects (PIPS)- See EQRO report at:
https://www.dhs.wisconsin.gov/familycare/statefedreqs/eqro2022-23.pdf

Performance Measures: See Care Management Review and Quality Compliance Review in the EQRO report at:
https://www.dhs.wisconsin.gov/familycare/statefedreqs/eqro2022-23.pdf

Provider Self-Report Data: PIHPs annually submit assurances that they do not knowingly employ or contract with excluded individuals or entities and that they have written policies and procedures to guard against fraud and abuse. PIHPs check the excluded provider registry upon initial contract with a provider.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Non-Nursing Home Level of Care	
Nursing Home Level of Care	
Partnership	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2022	12/31/2022	01/01/2023	12/31/2023
Enrollment Projections for the Time Period*	01/01/2025	12/31/2025	01/01/2026	12/31/2026

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

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

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Adult Day Care Services	☐	☐	☒	
Assistive Technology	☐	☐	☒	
Care Management (Support and Service Coordination)	☐	☐	☒	
CIE Exploration	☐	☐	☒	
Communication Assistance	☐	☐	☒	
Consultative Clinical and Therapeutic Services for Caregivers	☐	☐	☒	
Consumer Directed Supports (Self Directed Supports) Broker	☐	☐	☒	
Consumer Education and Training	☐	☐	☒	
Counseling and Therapeutic Resources	☐	☐	☒	
Daily Living Skills Training	☐	☐	☒	
Day Habilitation Services	☐	☐	☒	
Environmental Accessibility Adaptations (Home Modifications)	☐	☐	☒	
Financial Management Services	☐	☐	☒	
Health and Wellness	☐	☐	☒	
Home Delivered Meals	☐	☐	☒	
Housing Counseling	☐	☐	☒	
Personal Emergency Response Systems (PERS)	☐	☐	☒	
Prevocational Services	☐	☐	☒	
Relocation Services	☐	☐	☒	
Remote Monitoring and Support	☐	☐	☒	
Residential Services (1-2 Bed AFH)	☐	☐	☒	
Residential Services (Other)	☐	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Respite	☐	☐	☒	
Self-Directed Personal Care	☐	☐	☒	
Skilled Nursing Services RN/LPN	☐	☐	☒	
Specialized Medical Equipment and Supplies	☐	☐	☒	
Supported Employment - Individual Employment Support	☐	☐	☒	
Supported Employment - Small Group Employment Support	☐	☐	☒	
Supportive Home Care	☐	☐	☒	
Training Services for Unpaid Caregivers	☐	☐	☒	
Transportation (Specialized Transportation) - Community Transportation	☐	☐	☒	
Transportation (Specialized Transportation) - Other Transportation	☐	☐	☒	
Vehicle Modifications	☐	☐	☒	
Vocational Futures Planning and Support	☐	☐	☒	
AODA Day Treatment (excluding hospital-based or physician-provided)	☒	☐	☒	
AODA Services (excluding inpatient or physician-provided)	☒	☐	☒	
Case Management	☒	☐	☒	
Community Support Program (excluding physician provided)	☒	☐	☒	
Disposable Medical Supplies	☒	☐	☒	
Durable Medical Equipment (excluding hearing aids, prosthetics, and family planning supplies)	☒	☐	☒	
Home Health Services	☒	☐	☒	
Mental Health Day Treatment	☒	☐	☒	
Mental Health Services (excluding inpatient, physician-provided or comprehensive community services)	☒	☐	☒	
Nursing (including intermittent and private duty)	☒	☐	☒	
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)	☒	☐	☒	
Occupational Therapy (excluding inpatient hospital)	☒	☐	☒	
Personal Care	☒	☐	☒	
Physical Therapy (excluding inpatient hospital)	☒	☐	☒	
Respiratory Care	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Speech and Language Pathology Services (excluding inpatient hospital)	☒	☐	☒	
Transportation to Receive Non-Emergency Medical Care (excluding ambulance)	☒	☐	☒	
Ambulance Services	☒	☐	☒	
Ambulatory Surgical Center Services	☒	☐	☒	
Anesthesiology Services	☒	☐	☒	
Audiology Services	☒	☐	☒	
Blood	☒	☐	☒	
Chiropractic Services	☒	☐	☒	
Dental Services	☒	☐	☒	
Diagnostic Testing Services	☒	☐	☒	
Dialysis Services	☒	☐	☒	
Drugs (Prescribed)	☒	☐	☐	
Durable Medical Equipment (including hearing aids and prosthetics)	☒	☐	☒	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	☒	☐	☒	
Family Planning Services	☒	☐	☒	
Hospice Services	☒	☐	☒	
Hospital Inpatient Services	☒	☐	☒	
Hospital Outpatient Services	☒	☐	☒	
Mental Health Services - Inpatient	☒	☐	☒	
Nurse-Midwife Services	☒	☐	☒	
Physician Services	☒	☐	☒	
Podiatry Services	☒	☐	☒	
Private Duty Nursing Services	☒	☐	☒	
Rural Health Clinic Services	☒	☐	☒	
Vision Services	☒	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State?s waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS

Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State?s submitted CMS-64 forms.

Signature: KELLY VANSICKLEN

State Medicaid Director or Designee

Submission Date: Dec 17, 2025

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

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b. Name of Medicaid Financial Officer making these assurances:

Krista Willing

c. Telephone Number:

(608) 266-2469

d. E-mail:

KristaE.Willing@dhs.wisconsin.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

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.*

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

c. ☐ The State makes enhanced payments to contractors or providers.

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

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *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***
- 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.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☒ **MCO**
b. ☒ **PIHP**
c. ☐ **PAHP**
d. ☐ **PCCM**
e. ☒ **Other**

Please describe:

The PIHPs will not be at financial risk for Indian members choosing to receive care management from an Indian Health Care Provider (IHCP). The SMA will pay the PIHPs an interim monthly payment. The SMA will reconcile the interim payments. The PIHP receives the difference between the total non-administrative portion of the interim payments the SMA paid the PIHP before the member's cost share was deducted and the full cost of services the PIHP paid for Indian members receiving care management from an IHCP. The SMA will determine the full cost of services to be reconciled by totaling all encounters the PIHP submitted to the SMA for Indian members receiving care management from the IHCP. The reconciliation will take place annually within eighteen months of the calendar year in which the Indian member received services. The reconciliation could include recoupments from the PIHPs if actual service costs are less than the payments received from the SMA.

The administrative portion of the interim payments the SMA pays to the PIHP will be developed in accordance with the administrative rate methodology the SMA uses to develop the PIHP?s capitation payment for other populations.

The SMA will submit claims for 100% federal financial participation for payments to PIHPs only for Indian members receiving care management through the IHCP and only for those services provided by an IHCP.

The SMA may choose to pay the PIHPs an interim payment equal to the PIHP's capitation payment for other populations. The SMA acknowledges the cost data from the non-risk contract must be excluded from the data used to develop the capitation rates for the at-risk contracts.

The SMA will not need to establish a rate schedule for the 1915(c) waiver services within the PIHP contract. PIHPs and IHCPs can negotiate the rates the PIHP will pay as the interim payment to the IHCPs.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.

1. ☐ **Year 1:$** _____ **per member per month fee.**
2. ☐ **Year 2:$** _____ **per member per month fee.**
3. ☐ **Year 3:$** _____ **per member per month fee.**
4. ☐ **Year 4:$** _____ **per member per month fee.**

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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

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

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

Member months are expected to increase throughout the proposed waiver period based on historical growth experience. Enrollment growth trends are developed by PIHP/MCO, geographic service region, and rate cell based on historical data.

Member months are expected to increase by 1.9% from R1 (CY2022) to R2 (CY2023), -0.2% from R2 (CY2023) to P1 (CY2025), 3.1% from P1 (CY2025) to P2 (CY2026), 2.6% from P2 (CY2026) to P3 (CY2027), 2.5% from P3 (CY2027) to P4 (CY2028), and 2.4% from P4 (CY2028) to P5 (CY2029).

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

There is a 12-month gap (1/1/2024 - 12/31/2024) from the end of R2 (CY2023) to the beginning of P1 (CY2025). Enrollment was lower than usual during the Medicaid unwinding period. Actual enrollment growth during P1 (CY2025) has been higher than average resulting in a higher growth trend but is expected to return to longer term historical average trends in future periods.

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

R1 is 1/1/2022 - 12/31/2022. R2 is 1/1/2023 ? 12/31/2023.

Appendix D1 ? Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

- ☒ **[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:

The following 1915(c) waiver service categories have been added or enhanced beginning P1 (CY2025). These services were part of other existing service categories prior to P1 (CY2025); therefore, the State's contracted actuaries did not make any adjustment to service cost.

--Competitive Integrated Employment (CIE) Exploration is a new service category; however, the service has been provided under Supported Employment.

--Health and Wellness services are expanded; however, many of these services have been provided as Counseling and Therapeutic Resources.

--Remote Monitoring and Support is a new service category; however, communication devices have been covered under Assistive Technology. Monitoring costs may also be offset by a reduction in Supportive Home Care.

The following 1915(c) waiver services have been recategorized, but do not affect overall cost:

--Adaptive Aids (without Vehicle Modifications) has been added to the Assistive Technology (without Communication Aids) category.

--Adult Residential Care in and 3-4 Bed Adult Family Homes, Community Based Residential Facilities (CBRF), and Residential Care Apartment Complexes (RCAC) have been combined into a single Residential Services (Other) Category. Adult Residential Care in 1-2 Bed Adult Family Homes remains a separate category renamed Residential Services (1-2 Bed Adult Family Home).

--Communication Aids has been broken out as a separate service from the combined category of Assistive Technology / Communication Aids.

--Vehicle Modifications has been broken out as a separate service from Adaptive Aids.

Acute and primary services (other than prescription drugs) covered by Partnership have been added to the service listing. Costs for these services are included in the actual Partnership base period cost. Acute and primary care services in Appendix D3 are the same as those in Appendix D5. These services are excluded from Family care base costs and continue to be excluded through the waiver renewal period.

Prescription drugs are listed in the service table as being carved out of the Family Care and Partnership benefits. Drugs are available fee-for-service through the Medicaid State Plan.

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 Family Care participants, all primary and acute health care services are available fee-for-service through the Medicaid State Plan.

Partnership includes all Family Care covered services as well as acute and primary care services other than prescription drugs. Drugs are available fee-for-service through the Medicaid State Plan.

Appendix D2.S in the WMS portal lists services included in all MEGs combined. Appendix D2.S in the Excel cost effectiveness workbook separately identifies services by MEG.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Adult Day Care Services	☒	☐	☐	☒	☐	☐	☐
Assistive Technology	☒	☐	☐	☒	☐	☐	☐
Care Management (Support and Service Coordination)	☒	☐	☐	☒	☐	☐	☐
CIE Exploration	☒	☐	☐	☒	☐	☐	☐
Communication Assistance	☒	☐	☐	☒	☐	☐	☐
Consultative Clinical and Therapeutic Services for Caregivers	☒	☐	☐	☒	☐	☐	☐
Consumer Directed Supports (Self Directed Supports) Broker	☒	☐	☐	☒	☐	☐	☐
Consumer Education and Training	☒	☐	☐	☒	☐	☐	☐
Counseling and Therapeutic Resources	☒	☐	☐	☒	☐	☐	☐
Daily Living Skills Training	☒	☐	☐	☒	☐	☐	☐
Day Habilitation Services	☒	☐	☐	☒	☐	☐	☐
Environmental Accessibility Adaptations (Home Modifications)	☒	☐	☐	☒	☐	☐	☐
Financial Management Services	☒	☐	☐	☒	☐	☐	☐
Health and Wellness	☒	☐	☐	☒	☐	☐	☐
Home Delivered Meals	☒	☐	☐	☒	☐	☐	☐
Housing Counseling	☒	☐	☐	☒	☐	☐	☐
Personal Emergency Response Systems (PERS)	☒	☐	☐	☒	☐	☐	☐
Prevocational Services	☒	☐	☐	☒	☐	☐	☐
Relocation Services	☒	☐	☐	☒	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Remote Monitoring and Support	☒	☐	☐	☒	☐	☐	☐
Residential Services (1-2 Bed AFH)	☒	☐	☐	☒	☐	☐	☐
Residential Services (Other)	☒	☐	☐	☒	☐	☐	☐
Respite	☒	☐	☐	☒	☐	☐	☐
Self-Directed Personal Care	☒	☐	☐	☒	☐	☐	☐
Skilled Nursing Services RN/LPN	☒	☐	☐	☒	☐	☐	☐
Specialized Medical Equipment and Supplies	☒	☐	☐	☒	☐	☐	☐
Supported Employment - Individual Employment Support	☒	☐	☐	☒	☐	☐	☐
Supported Employment - Small Group Employment Support	☒	☐	☐	☒	☐	☐	☐
Supportive Home Care	☒	☐	☐	☒	☐	☐	☐
Training Services for Unpaid Caregivers	☒	☐	☐	☒	☐	☐	☐
Transportation (Specialized Transportation) - Community Transportation	☒	☐	☐	☒	☐	☐	☐
Transportation (Specialized Transportation) - Other Transportation	☒	☐	☐	☒	☐	☐	☐
Vehicle Modifications	☒	☐	☐	☒	☐	☐	☐
Vocational Futures Planning and Support	☒	☐	☐	☒	☐	☐	☐
AODA Day Treatment (excluding hospital-based or physician-provided)	☒	☐	☐	☒	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
AODA Services (excluding inpatient or physician-provided)	☒	☐	☐	☒	☐	☐	☐
Case Management	☒	☐	☐	☒	☐	☐	☐
Community Support Program (excluding physician provided)	☒	☐	☐	☒	☐	☐	☐
Disposable Medical Supplies	☒	☐	☐	☒	☐	☐	☐
Durable Medical Equipment (excluding hearing aids, prosthetics, and family planning supplies)	☒	☐	☐	☒	☐	☐	☐
Home Health Services	☒	☐	☐	☒	☐	☐	☐
Mental Health Day Treatment	☒	☐	☐	☒	☐	☐	☐
Mental Health Services (excluding inpatient, physician-provided or comprehensive community services)	☒	☐	☐	☒	☐	☐	☐
Nursing (including intermittent and private duty)	☒	☐	☐	☒	☐	☐	☐
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)	☒	☐	☐	☒	☐	☐	☐
Occupational Therapy (excluding inpatient hospital)	☒	☐	☐	☒	☐	☐	☐
Personal Care	☒	☐	☐	☒	☐	☐	☐
Physical Therapy (excluding inpatient hospital)	☒	☐	☐	☒	☐	☐	☐
Respiratory Care	☒	☐	☐	☒	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Speech and Language Pathology Services (excluding inpatient hospital)	☒	☐	☐	☒	☐	☐	☐
Transportation to Receive Non-Emergency Medical Care (excluding ambulance)	☒	☐	☐	☒	☐	☐	☐
Ambulance Services	☒	☐	☐	☐	☐	☐	☐
Ambulatory Surgical Center Services	☒	☐	☐	☐	☐	☐	☐
Anesthesiology Services	☒	☐	☐	☐	☐	☐	☐
Audiology Services	☒	☐	☐	☐	☐	☐	☐
Blood	☒	☐	☐	☐	☐	☐	☐
Chiropractic Services	☒	☐	☐	☐	☐	☐	☐
Dental Services	☒	☐	☐	☐	☐	☐	☐
Diagnostic Testing Services	☒	☐	☐	☐	☐	☐	☐
Dialysis Services	☒	☐	☐	☐	☐	☐	☐
Drugs (Prescribed)	☐	☒	☐	☐	☐	☐	☐
Durable Medical Equipment (including hearing aids and prosthetics)	☒	☐	☐	☐	☐	☐	☐
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	☒	☐	☐	☐	☐	☐	☐
Family Planning Services	☒	☐	☐	☐	☐	☐	☐
Hospice Services	☒	☐	☐	☐	☐	☐	☐
Hospital Inpatient Services	☒	☐	☐	☐	☐	☐	☐
Hospital Outpatient Services	☒	☐	☐	☐	☐	☐	☐
Mental Health Services - Inpatient	☒	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Nurse-Midwife Services	☒	☐	☐	☐	☐	☐	☐
Physician Services	☒	☐	☐	☐	☐	☐	☐
Podiatry Services	☒	☐	☐	☐	☐	☐	☐
Private Duty Nursing Services	☒	☐	☐	☐	☐	☐	☐
Rural Health Clinic Services	☒	☐	☐	☐	☐	☐	☐
Vision Services	☒	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

b. ☒ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☐ **Other**
Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

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:

This does not apply to the Nursing Home Level of Care and Non-Nursing Home Level of Care MEGs as the Family Care program is available statewide. Partnership, however, is available in only 18 out of 72 counties.

The issue of selection bias in the Partnership program is handled through the State's risk adjustment process. Risk adjustment has been a central component of rate setting from program inception. Historical costs of actual program enrollees are used as the base cost for the capitation rates. Functional status information obtained from the long-term care functional screen tool is used to risk adjust the long-term care portion of the capitation rates. The MCOs are paid a capitation that reflects case mix across 32 - 38 different measures of functional status. Acute and primary services are weighted by target group, Medicare eligibility status, age, and gender. The detail behind risk adjustment is contained in the rate report from the State's contracted actuary.

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**

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

   Stop loss is met by the State requiring working capital, restricted reserves, and pooled solvency fund contributions by each PIHP/MCO.

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.

   Document

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

i. The Department will provide an incentive payment to the PIHP/MCO of $1,000 for each member of a PIHP/MCO who is relocated from an institution into a community setting consistent with federal Money Follows the Person (MFP) guidelines. The incentive is a one-time payment paid to the PIHP per relocated member. The incentive payments themselves are not incorporated into rate setting for future years, but the service costs for the member are included in the encounter data used for future year rate setting.

ii. The amount of payment provided to a PIHP/MCO will be determined after the end of the contract year. The PIHP/MCO will submit before December 31 of the contract year a list of members for whom the PIHP anticipates a receipt of an incentive payment. The Department will compare the PIHP/MCO's list of members to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program to determine the number of relocations to use for calculation the incentive payment to the PIHP. The Department will notify the PIHP/MCO of the estimated amount of the incentive payment and the list of PIHP/MCO members for whom an incentive payment is being made prior to issuing the incentive payment.

iii. The approximate amount of anticipated incentive payment will be known prior to the end of the contract year. As described in the method above, the PIHP/MCO will submit before December 31 of the contract year a list of members for whom the PIHP/MCO anticipates a receipt of an incentive payment. The Department will compare the PIHP/MCO's list of members to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program.

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

Document:

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

Appendix D3 ? Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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: 7.03

   Please document how that trend was calculated:

   Nursing Home Level of Care MEG: 7.0%
   Non-Nursing Home Level of Care MEG: 6.9%
   Partnership MEG: 7.8%

   Trends from R2 (CY2023) to P1 (CY2025) are two-year adjustments. Nursing Home Level of Care trend adjustments are 2.8% from CY2023 to CY2024 and 4.0% from CY2024 to CY2025. Non-Nursing Home Level of Care trend adjustments are 3.1% from CY2023 to CY2024 and 3.6% from CY2024 to CY2025. Partnership trend adjustments are 3.2% from CY2023 to CY2024 and 4.5% from CY2024 to CY2025.

   Trends from R2 (CY2023) to P1 (CY2025) are developed by the State's contracted actuaries for both CY2024 and CY2025 capitation rates. Detail for the capitation rates and trend development can be found in the annual Capitation Rate Development Report for both years. The trend estimates for long term care services are developed for Developmentally Disabled, Physically Disabled, and Frail Elderly target groups for all Medicaid Eligibility Groups using standard actuarial practices based on actual CY2019, CY2021, CY2022, and CY2023 program service costs. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year. A separate overall trend is applied to acute and primary services in Partnership, consistent with historical experience.

2. ☒ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☒ **State historical cost increases.**

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

Years on which the rates are based: CY2019, CY2021, CY2022, CY2023, and CY2024.

Trends from R2 (CY2023) to P1 (CY2025) and P1 (CY2025) to P2 (CY2026) are developed by the State's contracted actuaries for CY2024, CY2025, and CY2026 capitation rates. Detail for the capitation rates and trend development can be found in the annual Capitation Rate Development Report for both years. The trend estimates for long term care services are developed for Developmentally Disabled, Physically Disabled, and Frail Elderly target groups for all Medicaid Eligibility Groups using standard actuarial practices based on actual CY2019, CY2021, CY2022, CY2023, and CY2024 program service costs. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year. A separate overall trend is applied to acute and primary services in Partnership, consistent with historical experience.

A 4.0% annual cost trend is assumed for P2 (CY2026) ? P3 (CY2027) using the trend in the current State budget.

A 3.0% annual cost trend is assumed for P3 (CY2027) ? P5 (CY2029) using the trend assumed in previous State budgets as cost trends are assumed to moderate in future periods.

Trend rates are as follows:

Nursing Home Level of Care: 7.0% (two-year trend) from R2 (CY2023) to P1 (CY2025), 3.4% from P1 (CY2025) to P2 (CY2026), 4.0 % from P2 (CY2026) to P3 (CY2027), 3.0% from P3 (CY2027) to P4 (CY2028), and 3.0% from P4 (CY2028) to P5 (CY2029).

Non-Nursing Home Level of Care: 6.9% (two-year trend) from R2 (CY2023) to P1 (CY2025), 3.6% from P1 (CY2025) to P2 (CY2026), 4.0 % from P2 (CY2026) to P3 (CY2027), 3.0% from P3 (CY2027) to P4 (CY2028), and 3.0% from P4 (CY2028) to P5 (CY2029).

Partnership: 7.8% (two-year trend) from R2 (CY2023) to P1 (CY2025), 5.2% from P1 (CY2025) to P2 (CY2026), 4.0 % from P2 (CY2026) to P3 (CY2027), 3.0% from P3 (CY2027) to P4 (CY2028), and 3.0% from P4 (CY2028) to P5 (CY2029).

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

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

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

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

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

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

Appendix D4 ? Adjustments in Projection

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

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

For the list of changes above, please report the following:

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

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 list the changes.

For the list of changes above, please report the following:

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

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

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

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

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

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

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

D. ☐ Other

Please describe

v. ☒ Other

Please describe:

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION

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

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP/MCO enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION.

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

0.00

Please describe:

D. ☒ Other

Please describe:

Adjustments are included to bring R2 (CY2023) to actual P1 (CY2025) reported in the CMS64.10. Service cost trends are used in P2 (CY2026) to P5 (CY2029). DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION.

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

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

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 lower of State historical 1915(b)(3) trend or State?s trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

   i. **A. State historical 1915(b)(3) trend rates**

      1. Please indicate the years on which the rates are based: base years
      2. Please provide documentation.

   B. State Plan Service trend

   Please indicate the State Plan Service trend rate from Section D.I.J.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

   Nursing Home: 7.0% to P1 (CY2025, 2-yr), 3.4% to P2 (CY2026), 4.0 % to P3 (CY2027), 3.0% to P4 (CY2028), and 3.0% to P5 (CY2029).

   Non-Nursing Home: 6.9% to P1 (CY2025, 2-yr), 3.6% to P2 (CY2026), 4.0 % to P3 (CY2027), 3.0% to P4 (CY2028), and 3.0% to P5 (CY2029).

   Partnership: 7.8% to P1 (CY2025, 2-yr), 5.2% to P2 (CY2026), 4.0 % to P3 (CY2027), 3.0% to P4 (CY2028), and 3.0% to P5 (CY2029).

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

   Not applicable. The State Plan service trend is used.

3. Explain any differences:

   Money Follow the Person incentive payments are accounted for in capitation costs as required in H.d.1; therefore, the trend rate for services is used.

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

p. ***Other adjustments*** including but not limited to federal government changes.

- 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. This adjustment must be mathematically accounted for in Appendix D5. Please describe

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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.

Appendix D5 is attached. Please refer to sections D.I.J.a.1., D.I.J.a.2.i., D.I.J.b.2.v.D., D.I.J.c.2.ii.D., and D.I.J.e. for detailed explanations of the adjustments.

Appendix D5 ? Waiver Cost Projection

Section D: Cost-Effectiveness

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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.

Appendix D6 is attached. Please refer to Section D.I.E. for detailed enrollment explanations.

Appendix D6 ? RO Targets

Section D: Cost-Effectiveness

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M. Appendix D7 - Summary

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

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

Member months are expected to increase throughout the proposed waiver period based on historical growth experience. Enrollment growth trends are developed by PIHP/MCO, geographic service region, and rate cell based on historical data.

Member months are expected to increase by 1.9% from R1 (CY2022) to R2 (CY2023), -0.2% from R2 (CY2023) to P1 (CY2025), 3.1% from P1 (CY2025) to P2 (CY2026), 2.6% from P2 (CY2026) to P3 (CY2027), 2.5% from P3 (CY2027) to P4 (CY2028), and 2.4% from P4 (CY2028) to P5 (CY2029).

There is a 12-month gap (1/1/2024 - 12/31/2024) from the end of R2 (CY2023) to the beginning of P1 (CY2025). Enrollment was lower than usual during the Medicaid unwinding period. Actual enrollment growth during P1 (CY2025) has been higher than average resulting in a higher growth trend but is expected to return to longer term historical average trends in future periods.

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:

Medicaid unit cost increases may be known in advance if the State Legislature has passed the relevant legislation. In those cases, the unit cost increases can be added into the capitation rate development in advance. This is appropriate because the PIHP/MCOs typically rely on the Medicaid fee schedule. If the Legislature acts after capitation rates have been developed, the rate increases may be added to the capitation rate in a retrospective adjustment.

Trends from R2 (CY2023) to P1 (CY2025) and P1 (CY2025) to P2 (CY2026) are developed by the State's contracted actuaries for CY2024, CY2025, and CY2026 capitation rates. Detail for the capitation rates and trend development can be found in the annual Capitation Rate Development Report for both years. The trend estimates for long term care services are developed for Developmentally Disabled, Physically Disabled, and Frail Elderly target groups for all Medicaid Eligibility Groups using standard actuarial practices based on actual CY2019, CY2021, CY2022, CY2023, and CY2024 program service costs. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year. A separate overall trend is applied to acute and primary services in Partnership, consistent with historical experience.

A 4.0% annual cost trend is assumed for P2 (CY2026) ? P3 (CY2027) using the trend in the current State budget.

A 3.0% annual cost trend is assumed for P3 (CY2027) ? P5 (CY2029) using the trend assumed in previous State budgets as cost trends are assumed to moderate in future periods.

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:

A separate adjustment for utilization change is not included. Utilization change is incorporated into the aggregate service cost trend adjustment. To develop rates based on expected CY2024, CY2025, and CY2026 member acuity levels, the State?s contracted actuary applies one year of projected acuity trend to the prior year acuity-adjusted costs (June 2023, May 2024, and May 2025 respectively).

As part of the historical trend study, changes in average acuity for CY2019 ? CY2025, excluding CY2020, were developed for each target population. The acuity trend study is performed in conjunction with the service cost trend study. These same acuity results are used to develop the risk adjusted service costs underlying the service cost trend development. Changes in average acuity are assumed to continue for future years.

An overall trend is applied to acute and primary services in Partnership, consistent with historical experience. Separate trends were not developed for utilization, unit cost, and acuity.

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

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP/MCO enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION.

Appendix D7 - Summary