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

This document is being utilized for a renewal of Alabama's 1915(b) waiver which governs the State's Maternity Care Program.

Submitted:
May 31, 2017

Contact:
Sylisa Lee-Jackson
Associate Director
Maternity, Plan First/Family Planning and Nurse Midwife Programs
Managed Care Division
Alabama Medicaid Agency
501 Dexter Avenue, P. O. Box 5624
Montgomery, Alabama 36103-5624
Office: (334) 353-4599
Fax: (334) 353-9356
sylisa.lee-jackson@medicaid.alabama.gov

Table of Contents

Facesheet 3
Section A: Program Description 5
Part I: Program Overview 5
A. Statutory Authority 9
B. Delivery Systems 11
C. Choice of MCOs, PIHPs, PAHPs, and PCCMs 12
D. Geographic Areas Served by the Waiver 14
E. Populations Included in Waiver 15
F. Services 18
Part II: Access 25
A. Timely Access Standards 25
B. Capacity Standards 27
C. Coordination and Continuity of Care Standards 28
Part III: Quality 31
Part IV: Program Operations 35
A. Marketing 35
B. Information to Potential Enrollees and Enrollees 37
C. Enrollment and Disenrollment 39
D. Enrollee Rights 44
E. Grievance System 45
F. Program Integrity 48

Section B: Monitoring Plan 50
Part I: Summary Chart 51
Part II: Monitoring Activities 54

Section C: Monitoring Results 56

Section D: Cost Effectiveness 59
Part I: State Completion Section 60
Part I: Appendices D1-7
Included in Attachment A

Exhibit A 100% Statewide RMEDE Report
Exhibit B Statewide Grievance Summary
Exhibit C REOMB Survey
Exhibit D REOMB Summary
Exhibit E Tribal Letter
Exhibit F District Mapping
Exhibit G County Codes Listing
Exhibit H Summary of Onsite Audit Findings

Exhibit I Global Associated Codes List
Attachment A Cost Effectiveness Worksheets

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

Facesheet

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

The **State** of Alabama requests a waiver/*renewal* under the authority of section 1915(b) of the Act. The Alabama Medicaid Agency will directly operate the waiver.

The **name of the waiver program** is Maternity Care Program. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:
N/A initial request for new waiver. All sections are filled.
N/A amendment request for existing waiver, which modifies Section/Part I.
A Program Description, Program Overview-Tribal Consultation
Program History; C. Choice of MCOs, PIHPs, PAHPs, and PCCMs, 1. Assurances, 2. Details; D. Geographic Areas Served by the Waiver, 1. General, 2. Details; F. Services
Section A: Program Description Part II: Access A.1Timely Access Standards, Assurances for MCO, PIHP, or PAHP programs
B.1 Capacity Standards, Assurances for MCO, PIHP, or PAHP programs
C.1 Coordination and Continuity of Care Standards, Assurance for MCO, PIHP or PAHP programs
Section A Program Descriptions
Part III Quality 1. Assurance for MCO, PIHP programs, 2. Assurance for PAHP Program
Section A, Program Description, Part IV Program Operations, Marketing, 1. Assurances
B.1 Information to Potential Enrollees and Enrollees, Assurances, C. Enrollment and Disenrollment, 1. Assurance, 2.b Details, Administration of Enrolment Process, D. Enrollee rights, 1. Assurance
N/A Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
X Document is replaced in full, with changes.
X renewal request
N/A This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
X The State has used this waiver format for its previous waiver period. Sections

C and D are filled out.

Section A is _X__ replaced in full

___ carried over from previous waiver period. The State:

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

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

Section B is X_replaced in full

___ carried over from previous waiver period. The State:

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

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

Effective Dates: This waiver/renewal/amendment is requested for an effective date of September 1, 2017/and ending with the effective date of August 31, 2019. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date).

State Contact: The State contact person for this waiver is Sylisa Lee-Jackson, R.N., ASN, BSMHR, and can be reached by telephone at (334) 353-4599, fax at (334)_353-9356, or e-mail at sylisa.lee-jackson@medicaid.alabama.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Currently, the Alabama Medicaid Agency (State) contracts with 12 administrative entities throughout the State for the provision of maternity services under this waiver authority. These entities are known as Primary Contractors. Primary Contractors, in turn, have the responsibility of establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care. Upon delivery, the Primary Contractor is paid an actuarially certified capitation fee and is responsible for paying subcontractors involved in the woman's care for services as identified in the Global Associated Code List (Exhibit I). The current program allows services provided by a physician associated with a teaching facility as defined in Section 4.19-B of the State Plan and high risk care provided by a board-certified Perinatologist to be excluded from the capitation payment methodology and to be reimbursed fee-for-service.

Individuals enrolled in the Maternity Care Program may receive care coordination, home visits and SBIRT services provided as (b)(3) services. More details about these services are provided under the description of (b)(3) services.

Tribal consultation
Alabama has one federally recognized tribe, the Poarch Band of Creek Indians with members primarily located in one county. The State works closely with tribal leaders to ensure that the Maternity Care Program does not interfere with the ability for tribal members to receive care. In Alabama, the medical center operated by the tribe is classified as a Federally Qualified Healthcare Center (FQHC) and is an enrolled Medicaid provider.

The clinic provides limited services; therefore, many tribal members seek care from community providers. To facilitate billing of these services, the State has provided the clinic a blanket referral process.

The State mailed a certified letter on January 17, 2017 to the Poarch Band of Creek Indians tribal chief informing the tribe of its intent to renew the 1915(b) Waiver. The purpose of this notice was to seek input and answer any tribal concerns related to the waiver renewal (Exhibit E). No responses were received as a result of this notice.

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).

<u>Maternity Care Program</u>
The Maternity Care Program began in 1988 under the original 1915(b) waiver authority. The waiver was developed in an effort to address Alabama's high infant mortality rate, the high drop-in delivery rate and the lack of Delivering Healthcare Professionals

participation. Up until January 1, 2016, Medicaid contracted with one administrative entity for the provision of maternity services in 14 Districts through a competitive bid process. This entity is known as the Primary Contractor. The Primary Contractor, in turn, has the responsibility for establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care.

Through a waiver amendment, the hospital component was removed from the Maternity Care Program on January 1, 2010. As a result of this amendment, inpatient care pertaining to the pregnancy diagnosis and postpartum days were transitioned to a fee-for-service payment methodology. Due to this modification, the program changed from a classification of a PIHP to a PAHP.

Since 1988, the State's 67 counties have been divided into 14 Districts for the operation of the Maternity Care Program. A five (5) year term Request for Proposal (RFP) was released in 2015 for the provision of maternity services for 14 Districts. Medicaid did not receive any proposals in response to the RFP for District 10 which covers Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike Counties. A second RFP was released with no responses. This resulted in atypical contracting circumstances in District 10. The maternity services provided to recipients in District 10 are reimbursed fee-for-service, consistent with the reimbursement mechanism for these services in the rest of the state.

Contracts under this RFP are termed for 12 months. The first contract extension began January 1, 2017 and will end on December 31, 2017. The Primary Contractor for District 12 which covers Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington counties did not executed a contact for calendar year 2017. This resulted in atypical contracting circumstances in District 12. The maternity services provided to recipients in District 12 are reimbursed fee-for-service, consistent with the reimbursement mechanism for these services in the rest of the state.

The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018. Medicaid anticipates the submission of a waiver amendment, contracts, RFP, rates and a revised Cost Effectiveness to CMS for consideration and approval.

There are notable exceptions to participation in the Maternity Care Program. These exceptions are based on exemption status, district assignments, and eligibility categories.

Maternity Care Program exemptions are allowed for eligible enrolled recipients. The recipient must be enrolled with a Primary Contractor before an exemption is considered. If a recipient is exempted, the financial responsibility for maternity services is not that of

the PAHP. These services are reimbursed fee-for-service to the direct provider of service. Exemptions are granted for the following reasons:

a. Medicaid Eligibility Granted Late in Pregnancy
   When the recipient applies for and receives Medicaid eligibility late in her pregnancy (third trimester which begins at 27 weeks gestation through delivery) or after delivery and has been receiving continuous care through a non-subcontracted provider, she may be eligible for a program exemption. The Primary Contractor must maintain documentation demonstrating a significant and unexpected financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application.

b. Private Managed Care/HMO
   If a recipient has insurance or a managed care plan, the Primary Contractor must maintain a copy of the policy or a letter from the insurer indicating the scope of coverage or that the recipient must use a prescribed provider network.

Recipients in the following categories are not required to enroll in the Maternity Care Program. The reimbursement for services provided to these recipients are reimbursed fee-for-service to the direct provider of service.

a. Non-citizens.

b. *Recipients residing in District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike counties).

c. *Recipients residing in District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington Counties).

   Recipients in District 10 and District 12 with SOBRA/Pregnant Women eligibility do not receive care coordination and home visits, however given the unique atypical contracting situation they are eligible to receive SBIRT services. SBIRT services are reimbursed fee-for-service, consistent with the reimbursement mechanism for services in the rest of the state.

* The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018. Care coordination and home visits are integrate components of the Maternity District Plans.

Maternity recipients with full Medicaid eligibility also fall under subsection Waiver authority 1915(b)(1). The State requires full Medicaid eligibility enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. Recipients with full Medicaid eligibility are assigned a primary medical physician (PMP) doctor, and must have a referral to see a doctor other than the assigned PMP. Maternity services are exempted from the referral requirements. Therefore, recipients in District 10 and 12 with full Medicaid eligibility receive care coordination through the primary care case management (PCCM) system. Home visits are not provided through the primary care case management (PCCM) system.

The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts.

Women with SOBRA/Pregnant eligibility are not required to receive medical care through a primary care case management (PCCM) system as Medicaid eligibility is determined based on the pregnancy state. Maternity-related services and non-maternity related services are exempted from referral requirements. These recipients are not under a PMPM capitation fee payment arrangement.

In addition, the following services are not the financial responsibility of the PAHP. These services are reimbursed fee-for-service to the direct provider of service.

a. High risk and routine maternity care services provided by a Teaching Physician as defined in State Plan AL-11-022, 4.19-B. The reimbursement for provision of high risk maternity care services provided by a teaching physician as defined in State Plan AL-11-022, 4.19-B, states in whole or in part " Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds" is excluded from the Waiver authority and may be billed fee-for-service.

b. High risk maternity care services provided by a Medicaid enrolled board-certified/board-eligible Perinatologist.

Waiver Changes Regarding Hemophilia as a (b)(3) Service

Hemophilia services were included in the previous waiver renewals as a 1915(b)(3) service. Language regarding Hemophilia services were removed from this extension application because the state was advised by CMS during the last waiver period to

remove the furnishing fee component. The state is following the guidance to reimburse for the Factor only through the pharmacy program, and is evaluating the other reimbursement through meetings with the provider community.

Maternity Care Program Highlights
Medicaid has worked diligently to ensure the Maternity Care Program encompasses an array of services and initiatives to decrease infant mortality and to improve birth outcomes of mothers and babies. In addition to prenatal, delivery and postpartum care, the following services are provided:

Application Assisters Program-Primary Contractors must have certified Application Assisters and Application Assisters' trainers in their district. The trainers assist recipients to maintain compliance with certification and re-certification requirements, obtaining eligibility quicker which enhances early entry into care. The Application Assisters is a 1915(b) Waiver service.

SBIRT-The State reimburses **outpatient** mental health services fee-for-service. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an authorized through the 1915(b) waiver as a (b)(3) service. Codes for pregnant women may be billed by Delivering Healthcare Professionals who have completed a training program and properly enrolled with Medicaid. These services include alcohol and/or drug screening and/or brief intervention. SBIRT is an authorized 1915(b)(3) Waiver services.

Face-to Face Tobacco Cessation Counseling- The State reimburses fee-for-service for up to four face- to-face counseling sessions in a 12-month period for Medicaid eligible pregnant women. The reimbursement period begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Face-to Face Tobacco Cessation Counseling is not an authorized 1915(b)(3) Waiver services. This service is reimbursed fee-for-service under State Plan authority.

The following number of services were provided in calendar year 2015 and 2016:

Calendar Year	Number of Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes	Number of Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
2015	2599	370
2016	1995	231

Medicaid pays for over half of all deliveries for the State of Alabama, approximately 56%. In 2015, the Alabama Medicaid Agency paid for 34,856 deliveries.

A. Statutory Authority

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

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

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

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

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

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

N/A MCO
N/A PIHP –
X__ PAHP *(Maternity Care Program)*
N/A 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.)
_N/A__ FFS Selective Contracting program (please describe)

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

a._X_**Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

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

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

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

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

B. Delivery Systems

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

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

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

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

__X_The PAHP is paid on a risk basis.
N/A The PAHP is paid on a non-risk basis.

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

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

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

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

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

1. **Assurances.**

_X__ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to

enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

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

Currently, within 12 districts of the Maternity Care Program, the State has one Primary Contractor through bid Procurement to serve as the administrative entity, through a competitive bid process. Providers who are willing to adhere to program requirements and who otherwise qualify must be given equal and fair participation opportunities. Complaints of discrimination will be investigated by Medicaid. The recipient has complete choice of those providers within her district. Throughout the life of the program, it has always operated with only one administrative entity in a district.

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

___ Two or more MCOs
_ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X_Other: (please describe) There is only one administrative entity for each 12 maternity care districts but the eligible has a choice of providers within the district.

3. **Rural Exception.**

_N/A__ 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**

_N/A__ Beneficiaries will be limited to a single provider in their service area (please define service area).

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

D. Geographic Areas Served by the Waiver

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

___ **Statewide**

X __ **Less than Statewide** *The waiver program will not be implemented in District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike Counties) and District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington Counties).

* The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018.

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.

Table 1.0

District	Name	Counties Served
District 1	**HealthGroup of Alabama**	Colbert, Franklin, Lauderdale and Marion
District 2	**HealthGroup of Alabama**	Jackson, Lawrence, Limestone, Madison, Marshall and Morgan
District 3	**Quality of Life Health Services, Inc.**	Calhoun, Cherokee, Cleburne, DeKalb and Etowah
District 4	**Greater Alabama Health Network**	Bibb, Fayette, Lamar, Pickens and Tuscaloosa
District 5	**Alabama Maternity, Inc.**	Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker and Winston
District 6	**Gift of Life Foundation, Inc.**	Clay, Coosa, Randolph, Talladega and Tallapoosa

District 7	**Greater Alabama Health Network**	Greene and Hale
District 8	**Greater Alabama Health Network**	Choctaw, Marengo and Sumter
District 9	**Greater Alabama Health Network**	Dallas, Perry and Wilcox
District 11	**Maternity Services of District 11, LLC.**	Barbour, Chambers, Lee, Macon and Russell
District 13	**Southeast Alabama Maternity Care, LLC.**	Coffee, Dale, Geneva, Henry and Houston
District 14	**University of South Alabama**	Mobile

E. Populations Included in Waiver

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

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

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

_X__ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment

___ Voluntary enrollment

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

X_ Mandatory enrollment
___ Voluntary enrollment

X **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.

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X__ Mandatory enrollment
___ Voluntary enrollment

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

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

_N/A__**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.

_X__ **Other Insurance--**Medicaid beneficiaries who have other health insurance. If it is a HMO with a limited network.

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

_N/A_ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program. _ N/A __ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

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

_X_ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes. (They can opt to participate in the program)

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

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

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

_X__ **Other** (Please define):

There may be individuals, decided on a case-by-case basis, who would not benefit from the program and may be exempted from participation. An individual may be eligible for a program exemption if she applies for and receives Medicaid eligibility late in her pregnancy (third trimester which begins at 27 weeks gestation through delivery) or after delivery, and has been receiving continuous care through a non-subcontracted provider. The Primary Contractor must maintain documentation demonstrating a significant and unexpected financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application. These individuals receive their services through Medicaid fee-for-service arrangement.

For the period of May 1, 2015 through December 31, 2016 one (1) recipient was considered for exemption but was denied due to the exemption criteria was not met.

Recipients residing in District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore,

Lowndes, Montgomery and Pike Counties) and District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington Counties) are also excluded from the waiver Program .

The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018.

F. Services

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

1. **Assurances.**

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

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

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

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

_N/A__ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services

will be available in the same amount, duration, and scope as they are under the State Plan.

_X__ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver. Pharmacy benefits are not included in either program.

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

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

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

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

Note: The program does not restrict access to emergency services. Recipients are informed on how to access emergency services. Emergency services are excluded from the capitation fee payment methodology and are reimbursed fee-for-service.

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:

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

_N/A_ 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

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

_N/A_ Other (please explain):

_X__ Family planning services are not included under the waiver.

The Maternity Care Program does not restrict access to family planning services and provides education to recipients on how to access these services. In addition, care coordination in the Maternity Care Program provides family planning services to include the importance of family planning along with written and oral instructions regarding forms of birth control provided through the Maternity Program and Plan First/Family Planning care coordination system. Recipients are also referred to the Plan First /Family Planning Program. Care coordinators review the importance of effective family planning methods and availability of family planning services, verify that the recipient has chosen birth control pills or any other method (condoms, injection contraception, etc.) of family planning and explain that this must be discussed with the Delivering Healthcare Professional during the hospitalization. They also explain the option of having a Long Acting Reversible Contraceptive implanted in the hospital immediately after delivery or in an outpatient setting immediately after discharge from an inpatient setting.

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:

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

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

Maternity Care Program
In the Maternity Care Program, FQHCs can either serve as a Primary Contractor or as a subcontractor. There is currently one FQHC serving as a Primary Contractor and six FQHCs serving as subcontractors with multiple clinic sites.

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

5. **EPSDT Requirements.**

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

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

_X__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.

Maternity Care Program

Home Visits
PREFACE: Home visits through the Maternity Care Program are an optional service and are at the discretion of the Maternity Primary Contractor's Care Management staff involved in the recipient's care. The program will allow flexibility for the Care Coordinator to make home visits based on the assessment and individualized needs of the recipient. A home visit is required if the hospital face to face encounter is missed. If the hospital face to face encounter is missed, a home visit must be made within twenty days of the delivery date. Medical records must be maintained that support the need or lack of need for the home visit and the outcome of the visit. The following criteria are published as a guide in determining who may need to receive a home visit.

A. Under 16 Years of Age

1. At time of conception
2. Late entry into care (20 weeks gestation and over)
3. Not residing in home with parents or spouse/significant other
4. Grossly overweight or underweight
5. Not in school
6. Use of tobacco and/or alcohol and/or drugs
7. Transportation issues
8. Lack of support from family or father of baby
9. Other triggers that may indicate a need for follow-up after delivery

B. Drug and Alcohol Abuse

1. Self reported
2. Psychosocial assessment
3. Odor of alcohol
4. Observations of track marks and/or bruises from needle use

5. Unexplained late entry into care 20 weeks gestation and over
6. At risk lifestyle (i.e., multiple sex partners)
7. Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

C. Mental illness

1. Postpartum depression (it is expected that these women may require a series of visits)
2. Long term history of mental illness
3. Taking psychotropic drugs for mental illness
4. Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

D. Birth weight 2500 grams or less

1. Prenatal care
2. Previous birth outcomes
3. Smoker
4. Enrolled in a hospital follow-up program

E. Other – this category allows for flexibility in looking at individual recipient's needs.

Care Coordination

An integral part of the medical care delivered through the Maternity Care Program is care coordination. Care coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program meeting the recipients' needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to care coordination varies from case to case. The needs of the recipient dictate when services are provided and the number of visits that are needed. Care coordination is provided to every recipient enrolled in the Maternity Care Program.

Initial Encounter are performed according to entry into care date. An Intake Form is completed and the form is faxed to the office of the Delivering Healthcare Professional of choice within five calendar days of the recipient's first Delivering Healthcare Professional's health visit. If the recipient does not have Medicaid financial eligibility, the Primary Contractor is responsible for immediately providing Application Assister services to aid the recipient in completing the application process.

Subsequent Encounters are required. An in-facility encounter must occur while the mother is still in the hospital after delivery. Other encounters will

be at the discretion of the care coordinator based on the level of complexity of the recipient needs, either medical or psychosocial. The encounters should be scheduled in order to help obtain the best outcomes and must be completed face-to-face.

Care coordination also include making referrals to other programs as necessary. Reimbursement for care coordination is through the PAHPs capitation fee reimbursement plan. Care coordination services are not provided to recipients in District 10 and District 12 through the PAHP.

The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018. Care coordination is an integrant part of the Maternity District Plan.

Screening, Brief Intervention and Referral for Treatment for Alcohol and Substance Abuse

Screening, brief intervention and referral to treatment (SBIRT) services for alcohol and substance abuse are provided to eligible pregnant women based upon the risk assessment which is completed by the delivering health care professional. The Department of Mental Health Substance Abuse Division provides training to the delivering health care professionals. The training focuses on early identification of those individuals with nondependent substance use , education on how to provide effective strategies for intervention prior to the need for more extensive or specialized treatment and brief treatment within the community setting or referral for those identified as needing more extensive services. This promoted healthier birth outcomes. Screening brief intervention and referral for treatment are services designed to identify individuals who are at risk for development of substance abuse disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse providers.

There are 25 Medicaid enrolled SBIRT providers in Alabama. The following number of services were provided for calendar year 2015 and 2016:

Calendar year	Alcohol and Drug Screening	Brief Intervention
2015	298	6
2016	156	26

Self-referrals.

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

Maternity Care Program

This program only covers pregnancy related services. Services must be provided for the purpose of supporting prenatal, delivery, or postpartum services. The following services while pregnancy related must be coordinated through the delivery health care professional, but are not the financial responsibility of the Primary Contractor. These services are reimbursed fee-for-service to the direct provider of service:

Drugs

A. Lab Services
B. Radiology *with the exception of maternity ultrasounds*
C. Dental – under 21
D. Physician – Physician fees for family planning procedures, circumcision code, routine newborn care codes, standby and infant resuscitation code.
E. Family Planning Services
F. Emergency Services
G. Transportation
H. Services Provided for Dropout/Miscarriages
I. Community Mental Health- Screening, Brief intervention, and Referral to Treatment (SBIRT)
J. Referral to Specialists – Office or in hospital visits provided by non-OB specialty physicians.
K. Non-Pregnancy Related Care
L. Services provided by a physician associated with a teaching facility
M. Services provided by a board-certified/board- eligible Perinatologist
N. Inpatient Care
O. Exemptions
P. Tobacco Cessation Face-to-Face Counseling
Q. Long Acting Reversible Contraception (LARC)- In an inpatient hospital setting immediately after a delivery or up to the time of inpatient discharge, or in an outpatient setting immediately after discharged from the inpatient hospital.
R. Durable Medical Equipment
S. Outpatient Emergency Room Services (claims containing a facility fee charge of 99281-99285 and associated physician charges 99281–99288)

T. Services for non-citizens

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

a. _N/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._N/A_ PCPs (please describe):

2._N/A_Specialists (please describe):

3._N/A_Ancillary providers (please describe):

4._N/A_Dental (please describe):

5._N/A_Hospitals (please describe):

6._N/A_Mental Health (please describe):

7._N/A_Pharmacies (please describe):

8._N/A_Substance Abuse Treatment Providers (please describe):

9._N/A_Other providers (please describe):

b. _N/A__ **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._N/A_ PCPs (please describe):

2._N/A_Specialists (please describe):

3._N/A_Ancillary providers (please describe):

4._N/A_Dental (please describe):

5._N/A_Mental Health (please describe):

6._NA_Substance Abuse Treatment Providers (please describe):

7._N/A_Urgent care (please describe):

8._N/A_Other providers (please describe):

c. _N/A__ **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._N/A__PCPs (please describe):

2._N/A_Specialists (please describe):

3._N/A_Ancillary providers (please describe):

4._N/A_Dental (please describe):

5._N/A_Mental Health (please describe):

6._N/A_Substance Abuse Treatment Providers (please describe):

7._N/A_Other providers (please describe):

d. _N/A__ **Other Access Standards** (please describe)

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

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

g. _N/A_**Other capacity standards** (please describe): .

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

a. _X_The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination. There is not a separate determination for enrollment with special health care needs. The State has defined individuals with special healthcare needs as individuals with on-going chronic conditions. The scope of services under this program is limited to pregnancy related. Care coordination is required for every enrollee. If special needs are found, there are mechanisms to address these needs through care coordination. In addition, if the woman's medical condition is such that it cannot or should not be treated through the Maternity Care Program, she can be exempted.

b. _N/A_**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. _N/A_**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.

d. _N/A_**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._N/A_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2._N/A_ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3._N/A_ In accord with any applicable State quality assurance and utilization review standards.

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

Reimbursement for specialists is not included in the capitation fee reimbursement methodology. However, if a specialist provide a pregnancy related service, services provided by the specialist are reimbursed fee-for-service.

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

Note: Details on the enrollment process are included in Section C.

a. _N/A Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

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

c. _N/A_ Each enrollee is receives **health education/promotion** information. Please explain.

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

e. _N/A_ There is appropriate and confidential **exchange of information** among providers.

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

g. _N/A__ 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. _N/A_ **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).

If these services are provided to a Patient 1st enrollee, information on services is provided to the PMP by the case manager.

i. _N/A__ **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.

N/A 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 III: Quality

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

N/A_ 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.

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

N/A 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.

N/A_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.

_N/A_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):

2. **Assurances For PAHP program.**

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

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

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

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

a. _N/A_.

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

1._ N/A _Provide education and informal mailings to beneficiaries and PCCMs;

2 N/A _Initiate telephone and/or mail inquiries and follow-up;

3._ N/A_ Request PCCM's response to identified problems;

4._ N/A_ Refer to program staff for further investigation;

5._ N/A_ Send warning letters to PCCMs;

6._ N/A _ Refer to State's medical staff for investigation;

7._ N/A_ Institute corrective action plans and follow-up;

8._ N/A_Change an enrollee's PCCM;

9 N/A _ Institute a restriction on the types of enrollees;

10._ N/A _ Further limit the number of assignments;

11._ N/A_ Ban new assignments;

12._ N/A_ Transfer some or all assignments to different PCCMs;

13._ N/A _ Suspend or terminate PCCM agreement;

14 N/A _ Suspend or terminate as Medicaid providers; and

15._N/A_ Other (explain):

c. _N/A __ **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. _N/A _Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. _N/A _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. _N/A _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. _ N/A _Initial credentialing

B. _N/A _Performance measures, including those obtained through the following (check all that apply):

_N/A__ The utilization management system.
_N/A __ The complaint and appeals system.
_N/A __ Enrollee surveys.
_N/A __ Other (Please describe).

4. _N/A _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. _N/A _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. _N/A _Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. _N/A_Other (please describe).

d. _N/A _**Other quality standards** (please describe):

N/A 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 criterion is weighted:

Section A: Program Description

Part IV: Program Operations

Marketing

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

1. **Assurances**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

1._ X __The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

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

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

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

1._X__The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this. Incentives are not allowed.

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

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

i._N/A_The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii._N/A_The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii._N/A_Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assuranc**es**.**

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The State defines prevalent non-English languages as:
(check any that apply):
1._X_ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”

Maternity Care Program
Primary Contractors throughout the state have translated their program specific information into Spanish. This is also available at the program level.

1. N/A The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
2. _N/A Other (please explain):

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

The Agency maintains a contract with a language line service that has the ability to translate any language and/or dialect. The operators manning this line are trained on how to assist non-English speaking individuals by connecting them with the language line. Providers also have the ability to refer patients to the 1-800 number for language assistance.

The Medicaid District offices also have installed a language assistive device known as "Prolingua". It is a computer based multilingual communication device that assists with the Medicaid application completion.

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

The State maintains a Recipient Call Center. This unit is available to explain program requirements. Additionally, program information is provided at the time of Medicaid application. Program information is always available on the Agency's website.

The Agency has established a web portal for recipient to use entitled "My Medicaid". Recipients are able to change their demographic information, request a replacement ID card, and check their benefit limits as needed.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X_ State
___ contractor (please specify) ________

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

c. Enrollee Information

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

(i) _X_ the State
(ii) _X_ State contractor (please specify): The Primary Contractor.
(iii) ___ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assuranc<u>es</u>.**

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

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

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

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

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

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

Maternity Care Program

Information that is provided at the time of application and specific district information is also provided at the time of eligibility determination. A brochure has been developed by the state outlining the districts throughout the State and provides direct access information for each district. A copy of the brochure is available on our website.

In addition, the Primary Contractor is responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate recipients and the community on the Maternity Care Program's availability and

services. Easily accessible program information is available at sites such as hospitals, physician offices, Social Security offices, DHR offices, health departments, community resource centers, tax refund offices, family planning centers, or other community areas. The Primary Contractor must coordinate with local communities, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the recipient. The Primary Contractors must have a system for recipients to receive information and ask questions regarding the Maternity Care Program.

b. **Administration of Enrollment Process**.

_X___State staff conducts the enrollment process.

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

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

Broker name: __________________

Please list the functions that the contractor will perform:

_N/A__ choice counseling
_N/A__ enrollment
_N/A__ other (please describe):

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

Participation in the Maternity Care program is mandatory except for beneficiaries who live in District 10 and District 12. Medicaid did not receive any proposals in response to the Request for Proposal for District 10 which covers Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike Counties. This resulted in atypical contracting circumstances in District 10. These maternity services provided to recipients in District 10 are reimbursed fee-for-service, consistent with the reimbursement mechanism for these services in the rest of the state.

Contracts under this RFP are termed for 12 months. The 1st contract extension began January 1, 2017 and will end on December 31, 2017. The Primary Contractor for District 12 which covers Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe and Washington counties did not execute a contact for calendar year 2017. This resulted in atypical contracting circumstances in District 12. These maternity services provided to recipients in District 12 are reimbursed fee-for-service,

consistent with the reimbursement mechanism for these services in the rest of the state.

The state will release a Request for Proposal (RFP) for the provision of maternity services under the Maternity District Plan for District 10 and District 12. The anticipated release date is August 4, 2017. The state anticipates responses to be submitted by vendors as a result of this Procurement. Services in District 10 and District 12 will be provided under the 1915(b) Waiver authority as maternity services in the rest of the districts. The effective date for the scope of work under this Procurement is January 1, 2018.

Exemptions are allowed. Recipients do have the ability to choose their delivering health care provider in their network. The Primary Contractor is required to perform this function. The Primary Contractor provides a list of all participating delivering physicians in the district to the recipient and the recipient chooses their delivering physician.

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

_N/A__ 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.):

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

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

i. ___ Potential enrollees will have____days/month(s) to choose a plan.
ii. __Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

_X__ The State **automatically enrolls** beneficiaries
_N/A__ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

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

_N/A__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: ____________

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

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

Maternity Care Program

The purpose of a program exemption is to allow a recipient to receive care outside the established Maternity Care Program districts.

The following are standard exemption reasons:

Medicaid Eligibility Granted Late in Pregnancy – When the recipient applies for and receives Medicaid eligibility late in her pregnancy (3rd trimester) or after delivery and has been receiving continuous care through a non-subcontracted provider, a program exemption can be requested.

TPL – if the recipient has an HMO type insurance that requires that care be received from certain providers and those providers are not part of the Maternity Care network, an exemption can be requested.

Procedure For Exemption – The recipient or provider shall request an exemption from the Primary Contractor prior to delivery on the standardized program exemption form. The state reviews the requests. If approved, an indicator is placed on the system for all claims to bypass the Maternity Care edits. If denied, the provider and/or recipient can request reconsideration.

N/A 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.

NOTE: Maternity recipients retain eligibility throughout the pregnancy.

d. **Disenrollment:**

_N/A_ 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._N/A__ Enrollee submits request to State.

ii._N/A__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._N/A__Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

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

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

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

Maternity Care Program

Within the first 90 days of enrollment in the Maternity Care Program, a recipient can change her chosen physician for no cause. After the initial 90 days, the recipient can change, but cause must be stated.

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

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

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

iii. _N/A__ 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. _N/A_ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

N/A_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.

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

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

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

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

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

_N/A_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**

_N/A_The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _?__ days (between 20 and 90).

_N/A_ The State's timeframe within which an enrollee must file a **grievance** is _?_ days. The State does not limit the timeframe.

c. **Special Needs**

_N/A_The State has special processes in place for persons with special needs. Please describe.

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.

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

_X_ The grievance procedures is operated by:

_X_ the State

___ the State's contractor. Please identify: ___________

___ the PCCM

___ the PAHP.

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

The State utilizes the following definitions:

1. Grievances: Written communications explicitly addressing dissatisfaction about any matter other that an action which may include the following: the availability, quality, payment, treatment, reimbursement of claims for services, and/or unresolved issues through the complaint process.

2. Appeal: a request for review of an action.

An action is defined as:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a services
- The failure to provide services in a timely manner
- The failure of the entity to act within timeframes provided in 438.408

The types of request for review that can be made in the PAHP grievance system (e.g. grievance appeals) includes the following:

Complaint Code	**Statewide 2015**	**Statewide 2016**
A Staff	21	14
B Medical/MD	147	105
C Environment	19	9
D Billing	1	1
E Communications	10	13
F Time	13	7
G Transportation	40	43
H Other	36	47
Total	287	239
Total Deliveries	29,769	25,686

_X__ 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.

The Maternity Care Program Quality Assurance Nurses review all reported complaints and grievances for trends and resolution. Complaints that are reported to the State directly by a recipient or provider are follow-up with the Primary Contractor until resolution.

X_ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _60_ (please specify for each type of request for review)

_X_ Has time frames for resolving requests for review. Specify the time period set: __30___ (please specify for each type of request for review)

_X__ Establishes and maintains an expedited review process for the following reasons:______ . Specify the time frame set by the State for this process_15 days.

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

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

_N/A__Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

The prohibited relationships are:

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

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

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

2. **Assurances For MCO or PIHP programs**

_N/A_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.

N/A_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.

_N/A__ 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.

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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

II. Details of Monitoring Activities

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

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

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

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

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

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

___ NCQA
___ JCAHO
___ AAAHC
_X__ Other (please describe) Providers must be Medicaid enrolled providers to participate in the programs. Provider enrollments are done by HP Medicaid's fiscal agent. As part of the enrollment process licensing and certification is accomplished. By requiring the provider to be enrolled, the State can be assured that the provider is qualified. As part of the routine enrollment process, there is assurance that the provider has also not been sanctioned.

c. __X___ Consumer Self-Report data

CAHPS (please identify which one(s))

_X__ State-developed survey The State utilizes REOMB to survey patients about services received. An example of the survey is noted in Exhibit C. A summary of REOMB activities are noted in Exhibit D.

___ Disenrollment survey
___ Consumer/beneficiary focus groups

d. _X___ Data Analysis (non-claims)
___ Denials of referral requests
__X_ Disenrollment requests by enrollee
_X__ From plan
___ From PCP within plan
_X__ Grievances and appeals data – The Maternity Care Program Primary Contractor are required to submit quarterly grievance reports to the State agency. A Statewide Grievance Summary Report is generated and shared with the Maternity Care Primary Contractors (Exhibit B).
___ PCP termination rates and reasons
___ Other (please describe)

e. _X____ Enrollee Hotlines operated by State
The State, through its fiscal agent, maintains a recipient call center. Recipients can call the toll free number for program information, including submitting a request for a replacement Medicaid cards, contact Agency staff to address specific needs, report fraud or to report any problems.

f. _X____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service). Focus studies are required from the Primary Contractors. They identify through their own QA issues topics what would fit their areas.

g. _X____ Geographic mapping of provider network

Maternity Care Program
As part of the RFP process, potential bidders are required to provide the geographic distribution of all their subcontractors. Primary Contractor must contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district. If there are no in-district providers that would ensure that every recipient meets the 50 miles requirement, the Primary Contractor is responsible for establishing a network of providers and may have to pursue contracts with out of district providers.

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

The last assessment was completed in November 2008. We have completed two waiver periods and interpret that this is no longer required.

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

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

The State requires the Maternity Care Program Contractor to notify Medicaid within one business day of any unexpected changes that would impair its provider network. This notification shall include information as to how the change shall affect the delivery of covered services and the Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

k. _NA__ Ombudsman

l. _X__ On-site review

Onsite administrative audits are conducted of the Primary Contractors annually. The purpose of the audit is to ensure compliance with program regulations. In CY 2015, two (2) Primary contractors were under corrective action and in CY 2016, ten (10) Primary Contractors were under corrective action. Primary Contractors lacked documentation to support community outreach and subcontractor's education was completed. One (1) Primary Contractor lacked adequate documentation to support annual federal database and physician hospital privileges validations were completed.

m. _N/A Performance Improvement projects [**Required** for MCO/PIHP]
__N/A Clinical

N/A Non-clinical – refer to f above
N/A___ Performance measures [**Required** for MCO/PIHP]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics

Beneficiary Characteristics

o. _N/A__ Periodic comparison of number and types of Medicaid providers before and after waiver

p. _N/A__ Profile utilization by provider caseload (looking for outliers)

q. _N/A__Provider Self-report data
___ Survey of providers
___ Focus groups

r. _N/A__ Test 24 hours/7 days a week PCP availability
s. _N/A_ Utilization review (e.g. ER, non-authorized specialist requests)

t. _X__Other: (please describe) Medical record reviews. Medical record reviews are conducted biannually for each Primary Contractor. The purpose of these reviews is to determine if services were provided according to program guidelines and to determine program quality. Medicaid will also monitor access to care for recipients in District 12 to ensure that access to care is not limited in rural areas. Data will be evaluated to look at changes in infant mortality and/or drop in delivery rates.

Section C: Monitoring Results

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

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

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

_X_ This is a renewal request.

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

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

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

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State
- need not identify the provider/plan by name, but must provide the rest of the required information..
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:
Enrollee hotlines are not a measurable activity; therefore, they are not addressed below.

1. Strategy: Confirmation it was conducted as described: Recipient Explanation of Medical Benefits (REOMB) are forwarded to recipients on a monthly basis (Exhibit C).
_X__ Yes
___ No. Please explain:
Summary of results: The return rate averages approximately 8%. Overall, recipient are satisfied with their maternity services. In CY 2015, 7414 REOMBs were mailed and 577 were returned, an 8% return rate. In CY 2016, 6384 REOMBs were mailed and 388 were return, an 6% return rate.
Problems identified: There continues to be a less than optimal response rate for REOMBS but the overall response to the services received were positive.
Corrective action (plan/provider level): None.

Program change (system-wide level): None.

2. Strategy:
Confirmation it was conducted as described:
_N/A__ Yes
N/A___ No. Please explain:
Summary of results:

Corrective action (plan/provider level):
Program change (system-wide level):

3. Strategy: Geographic Mapping of Provider – Maternity Care Program
Confirmation it was conducted as described:
_X__ Yes-Requirements for geographic mapping were evaluated during the RFP review process.
____ No. Please explain:

Summary of results: All Primary Contractors exhibited the ability to provide access to delivering healthcare professionals within 50 miles/50 minutes of women within their district.
Problems identified: None.
Corrective action (plan/provider level): None.
Program change (system-wide level): None.

4. Strategy:
_N/A__ Yes ___ No. Please explain:
Summary of results: No problems of access have been identified.
Problems identified: None.
Corrective action (plan/provider level): None.
Program change (system-wide level): None.

5. Strategy:
_N/A__ Yes
___ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level):
Program change (system-wide level):

6. Strategy: Network Adequacy Assurance Submitted by Plan (Maternity Care Program)
Confirmation it was conducted as described:
_X__ Yes - Refer to 3 in this section.
___ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level):
Program change (system-wide level):

7. Strategy: On-site reviews (Maternity Care Program)
Confirmation it was conducted as described:
_X__ Yes - Annually, each Primary Contractor receives an on-site review. Areas reviewed include billing and disbursement, exemption files, subcontracts, and care coordinator licensing requirements. The on-site review also gives the State the opportunity to review and document first hand program operations.
___ No. Please explain:
Summary of results : Reference Exhibit H for a summary of on-site review findings.

Problems identified: Compliance with subcontractors' education and community outreach.
Corrective action (plan/provider level): Yes
Program change (system-wide level): None. No program changes but education was provided during the on-site reviews.

8. Strategy: Performance Measures (Maternity Care Program)
Confirmation it was conducted as described:
_X__ Yes -
___ No. Please explain:
Summary of results: 100 % Statewide RMEDE Reports were developed using the following quality and performance measures (Exhibit A).

Problems identified: Yes
Corrective action (plan/provider level): Yes, Primary Contractors were put under corrective action for not meeting benchmarks.

Program change (system-wide level): None

Section D – Cost-Effectiveness

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

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

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

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect

their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: John (David) McIntosh

c. Telephone Number: (334) 353-3533

d. E-mail: John.McIntosh@medicaid.alabama.gov

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

__ date of payment.

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

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

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

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

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

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

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

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

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

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

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

a.___ MCO

b___ PIHP

c **X** PAHP

d.___ Other (please explain):

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

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

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

1._ _ First Year: per member per month fee

2._ _ Second Year: per member per month fee

3.___ Third Year: $____ per member per month fee

4.___ Fourth Year: $ per member per month fee

b._**N/A**__ 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._N/A_ 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.

CMS will approve the shared savings methodology during each waiver period before it can be implemented.

d.___ Other reimbursement method/amount. $______ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

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

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

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

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

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

For Conversion or Renewal Waivers:

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

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

c._**X**_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: Have had minor variation during the previous waiver period. Eligibility for District 10 and District 12 members has been removed from both the base and projection. Eligibility from counties which will be instead covered by Regional Care Organizations on October 1, 2017 have been removed from the projections beginning October 1, 2017.

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

e. _**X**_ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: State fiscal years 2015 and 2016.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: B3 services not related to the Maternity Care Program were removed.

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

taken into account: Since eligibles receiving long term care services will not be enrolled in this waiver, the following services were excluded from the cost-effectiveness analysis: nursing facility care, ICF/MR, nursing facility-MD, ID waiver, MR/Living At Home waiver, Elderly & Disabled waiver, Hospice, Homebound waiver, PACE, ACT Waiver, Medicare HMO, inpatient hospital and targeted case management for the medically at-risk.

Additionally, services not covered by the waiver were excluded. For the Maternity Care Program, the capitation payment and any b(3) services were included.

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

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

For Initial Waivers:

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

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)			
Total			

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._**X**_ Other (Please explain). Only those administrative costs directly associated with the waiver were included.

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)			
Total			

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
SBIRT	$9,806 or $0.05 PMPM in R1 $4,422 or $0.02 PMPM in R2	2.2%	$6,818 or $0.04 PMPM in P1 $7,064 or $0.04 PMPM in P2
Care Coordination	$6,406,566 or $30.98 PMPM in R1 $5,781,908 or $31.48 PMPM in R2	2.2%	$5,927,895 or $32.64 PMPM in P1 $6,141,717 or $33.36 PMPM in P2
Home Visits	$285,768 or $1.38 PMPM in R1 $257,905 or $1.40 PMPM in R2	2.2%	$264,416 or $1.40 PMPM in P1 $273,954 or $1.46 PMPM in P2

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

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

Basis and Method:

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

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

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

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

i. Document the criteria for awarding the incentive payments.

Document the method for calculating incentives/bonuses, and

ii. 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.

The State will monitor the quarterly 64.9 Waiver submissions to ensure that the total payments to PMPs in P1 do not exceed the Waiver Cost Projection.

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

Current Initial Waiver Adjustments in the preprint

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

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

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

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

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

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

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

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

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

reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

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

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

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

Others:

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

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

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

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

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

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

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

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

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

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

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

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

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

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

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

C.____Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._______

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

3. Explain any differences:

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

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

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

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine GME adjustment based on a pending SPA.

3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

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

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

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

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

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

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

Method:

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

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

Basis and method:

1.___ No adjustment was necessary

2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.

3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4.___ The State made this adjustment:*

i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**

ii.___ Other (please describe):

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

Basis and Method:

1._ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

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

DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

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

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

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
   a. ___Potential Selection bias was measured in the following manner:
   b.___The base year costs were adjusted in the following manner:

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

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

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

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

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

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

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

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

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

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

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

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

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

1._X_ [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 2005 to present)* The actual trend rate used is: For the maternity MEGs, the average annual trend applied from the retrospective time period to the prospective time periods was 2.2%.

Please document how that trend was calculated: The State used the following approach to calculate PMPM.

Numerator

To calculate the numerator the State calculate the cost of deliveries in the quarter based on the

a. Total Primary Contractor's global/capitation payments paid for prenatal, delivery, and post-partum care in report quarter (based on initial paid date)
b. Administrative cost for AMA to manage waiver and supervise contractors

All other cost associated with maternity recipients would be excluded because they are not specifically part of the waiver.

Denominator

a. Member months are reported for only women who deliver (for whom we pay a global/capitation fee) during the target quarter.

Initial payment is all that is captured. The State excluded adjustments to avoid duplicate counting.

b. For each of the recipients, the State includes all months eligible during the pregnancy in the delivery. Recipients who are currently pregnant would be excluded from the calculation.

c. Since fully eligible recipients do not have a formal begin and end date for eligibility under the waiver the State reviewed historical membership and used a standard 9.09 months eligible for each recipient. This would include approximately 7 months prior to delivery and 2 months for post-partum care. This standard allows for consistency and is appropriate because the State recognized that the cost of services under the waiver does not vary by the number of months eligible.

Other cost for non-SOBRA Maternity recipients is excluded because it is paid based on an authority outside the waiver.

The trends were calculated using claims data. The trend data was normalized for fee changes to ensure that the program changes were not duplicated in the trend analysis. The State used the lower of their actual projected trends and the President's trend rate.

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

i. _**X**_ State historical cost increases. Please indicate the years on which the rates are based: base years October 2014 to September 2016. 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**.**

The State considers historical year trends as well as rolling averages when developing these estimates. The estimates are PMPM trends and therefore reflect the components mentioned related to both cost as well as utilization.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _______________. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation

includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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

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

b. __X_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R1 and R2 data was adjusted for changes that will occur after the R1 and R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

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

- i. X The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
  - *A.*____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
  - *B.*____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
  - *C.* X Determine adjustment based on currently approved SPA. PMPM size of adjustment $9.63 for Maternity in P1. This adjustment is not duplicative with trend, as the adjustment is set to, combined with trend, produce the projected PMPM for P1. This projection excludes the projected PMPM for Districts 10 and 12.
  - *D.*____Other (please describe):
- ii. __ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv.__ Changes brought about by legal action (please describe): For each change, please report the following:
  - A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
  - B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment __
  - C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
  - D.____Other (please describe): Cost were adjusted to account for the mandated increase of primary care services for Medicare rates beginning CY 2013.
- v.__ Changes in legislation (please describe): For each change, please report the following:
  - A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
  - B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment

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

D.____Other (please describe):

vi.__ Other (please describe):

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

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

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

D.____Other (please describe):

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

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i._X_ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe: Cost increases were accounted for.

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

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

C._X_ State Historical State Administrative Inflation. The actual trend rate used is: 2.7%. Please document how that trend was calculated:

The annual trend rate of 2.7% was used to project base period administrative costs to P1 and P2, consistent with historical administrative cost increases and US Consumer Price Index inflation.

D.__Other (please describe):

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

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

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1._**X**_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 2005 to present).* The actual documented trend is: 3.5% Maternity for P1 and P2. Please provide documentation. The (b)(3) services offered through this waiver for the Maternity population are screening for alcohol and drug use, brief intervention and referral for treatment.

As the 3.5% is greater than the state plan services trend of 2.2%, the state plan services trend is used.

The costs for the screening, brief intervention and referral for treatment services were obtained from projections in collaboration with the Department of Mental Health. For B3 services, CY 11 through 14 was compared and the percent difference was used to calculate an adjustment

rate for each MEG. The State used the lower of their actual projected medical trends and the President's trend rate.

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

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

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

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

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

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

1. List the State Plan trend rate by MEG :

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. N/A

3. Explain any differences: The Agency expects to make a onetime payment in P1 to providers, but the amount and methodology has not yet been determined; therefore, no trend rate is applicable.

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

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

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

  Basis and Method:

  1.__ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.

  2._X_ 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.

  3.___ Other (please describe):

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

   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**: **Growth and declines for each MEG will follow historical trends.**

   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**:
      Unit cost changes were not analyzed to aid in determining adjustments. Instead, the State chose to develop trends which did not separate changes in unit costs, utilization, practice patterns, technology, or other factors contributing to overall changes in PMPM expenditures.

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**:
   See our response to 2. above.

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

Part II: Appendices D.1-7

See attached Excel spreadsheet-Attachment A.