Plan First Waiver Program

Section 1115 Demonstration Waiver

Annual Report

Demonstration Year 16

Fiscal Year 16

March 30, 2017

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Alabama's
Plan First Section 1115 Demonstration Waiver
Annual Report
Demonstration Year 16
Fiscal Year (October 1, 2015 through September 30, 2016)
Annual Report Period (January 1, 2016 through December 31, 2016)
March 29, 2017

I. Introduction

The Alabama Medicaid Agency's (Medicaid) Plan First Program began October 1, 2000. It represents a collaborative effort between Medicaid and the Alabama Department of Public Health (ADPH). The Plan First Program increases the availability of family planning services to all women of childbearing age (19-55) with incomes at or below 141% of the federal poverty level (FPL) that would not otherwise qualify for Medicaid or lost Medicaid coverage 60 days postpartum. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income. The Plan First Program was predicated on the recognized need for continued family planning once Medicaid Maternity eligibility was terminated after the postpartum period, and for those women who would not otherwise qualify for Medicaid unless they were pregnant.

The previous Waiver was approved for effective dates of April 12, 2012, through December 31, 2013. CMS granted an extension for effective dates of June 27, 2013, through December 31, 2014. Medicaid requested an extension of the Section 1115 Plan First Demonstration Waiver and an approval was granted by CMS for effective dates of December 29, 2014, through December 31, 2017, three (3) years. During this renewal, two new covered services were added, removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility and coverage of vasectomies for eligible males 21 years of age or older.

A waiver amendment was submitted to CMS in November 2016 requesting approval to provide care coordination to Plan First males enrolling to receive a vasectomy/vasectomy related services. This will be an abbreviated version of care coordination service. The goal of care coordination for males is to help the male obtain Medicaid eligibility and navigate the system in order to have the vasectomy procedure and follow-up visits completed successfully. The service will also provide assistance with locating the appropriate doctor to perform the procedure. Ensuring that all barriers are removed may prevent and/or delay unintended pregnancies.

Risk and psychosocial assessments will not be provided to the males. The following services will be provided:

1. Establish the male's Medicaid status. If the male is not on Medicaid, assist him with the completion of the Lavender Plan First application. Continue to follow-up with male until Medicaid is verified as active.
2. Provide the recipient with a list of Medicaid approved providers for completion of the vasectomy procedure.

3. Once the recipient selects a provider, make an appointment for the initial consultation with the provider.
4. Assist with completion of the consent form. The social worker will submit the paperwork to the selected provider making sure the proper releases have been signed.
5. Provide appointment reminders to the recipient for the office visit.
6. Follow-up with the provider to ensure the recipient keeps all appointments. If the recipient does not keep appointments and follow-up appointments, make contact with the recipient to re-schedule appointments. After two missed appointments, discuss with the recipient if he has changed his mind regarding the procedure. If not, assist with overcoming barriers that are impeding his ability to keep the appointment.
7. Follow-up with the recipient after the procedure to assess for any residual issues.
8. Close the case once the recipient has completed the follow-up appointment and no other needs are identified.

Care Coordination will be provided by licensed social workers or registered nurses through the Alabama Department of Public Health. Care coordination services are available to all Plan First male recipients, regardless of the service provider. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First care coordinator. The Waiver amendment to add care coordination as a covered service for males is still under review by CMS.

II. Executive Summary

Plan First is designed to improve the well-being of children and families in Alabama whose income is at or below 141% of the Federal Poverty Level (FPL) by extending Medicaid eligibility for family planning services to eligible childbearing women between the ages of 19-55 and males, ages 21 or older, for vasectomy related services only. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

Recipients have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services. There are no co-payments on prescription drugs/supplies that are designated as family planning.

Plan First enrollees must meet one of the eligibility criteria described below.

Group 1

Women 19 through 55 years of age who have Medicaid eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer "yes" to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is re-determined every 12 months.

Group 2

Poverty level pregnant women 19 through 55 years of age whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First Program receive a computer generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered "no" to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children. Eligibility is re-determined every 12 months.

Group 3

Other women age 19 through 55 years of age who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient's declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is re-determined every 12 months.

Group 4

Plan First men, ages 21 and older, wishing to have a vasectomy may complete a simplified shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

In February 2013, AMA implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. Medicaid's eligibility system automatically completes the renewal process using a monthly data match with the SNAP and TANF programs. Plan First women and Medicaid children due to renew and found to be active on SNAP, TANF or both are automatically renewed and a renewal notice is generated and sent to the renewed household. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the enrollment process.

The Alabama Medicaid Agency uses the Federal Hub services to verify income (IRS, SSA, Equifax), SSN, citizenship and alienage, (DHS) as well as other sources (SVES, SDX, PARIS, SNAP, TANF, EDB, vital statistics,) to verify income and other points of eligibility as listed in the Alabama verification plan.

Alabama also has a Hub waiver through which we use The SAVE web system (Systematic Alien Verification for Entitlements) for the VLP (verify lawful presence) steps 2 and 3 as needed. VLP 1 is completed through the Federal Hub. Alabama uses the hub service for on-line identity verification.

For income, Alabama uses the following reasonable compatibility model:

1. If available databases find no match, self-attestation will be accepted.
2. If individual self-attestation of income and data match are both below the Medicaid/CHIP MAGI eligibility level, individual will be determined eligible for Medicaid/CHIP benefits.
3. If individual self-attestation of income and data match are both above the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible, and account transferred to FFM for APTC eligibility.
4. If individual self-attestation of income is above Medicaid/CHIP MAGI level, but data match puts applicant below the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible and account transferred to FFM for APTC eligibility.
5. If individual self-attestation of income is below Alabama Medicaid/CHIP MAGI level, but data match puts applicant above the Medicaid/CHIP MAGI eligibility level, reasonable compatibility level of 10% will be applied. If less than 10% difference, data is considered reasonably compatible and individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual can provide a reasonable explanation (either already indicated on the application, or after formal request from the state), the individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual cannot provide a reasonable explanation, the individual will be determined ineligible for Medicaid/CHIP.

Individuals may also renew on-line and receive a real-time eligibility renewal without worker intervention with real time eligibility verification through the Federal Hub.

Upon eligibility approval, recipients receive an award letter informing them of their Medicaid coverage. A letter is also generated if the recipient's services are denied, terminated, suspended, or changed. Appeal rights are included in the letter.

The following goals and hypotheses were targeted for DY 16:

- Increase the portion of income eligible women, ages 19 –55 enrolled in Plan First and reduce race/ethnicity and geographic disparities among enrollees. **Goal-Enroll 80% of all eligible clients (based on census estimates of the eligible population) under age 40 across all race/ethnicity and geographic area groups, thereby eliminating disparities across these groups. Census data will be used to generate estimates of the eligible population.**

- Maintain the high level of awareness of the Plan First Program among program enrollees. **Goal-90% of surveyed enrollees will have heard of the program and 85% of these will**

be aware that they are enrolled in the program. Telephone surveys of enrollees will be used to track changes in levels of awareness of the program and enrollment in the program.

- Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care. **Goal-70% utilization of services by the end of the three year period, along with a 70% rate for 12 and 24 month return visits for individuals using services during the renewal period. Data will be generated from service use claims data and delivery data.**

- Survey data suggest that approximately one third of Plan First enrollees are cigarette smokers, and 85% of these were advised by their family planning providers to quit smoking. **Goal-25% of Plan First service users (85% of the 30% who are smokers) will receive either a covered Nicotine Reduction Therapy (NRT) prescription, a referral to the Quit Line or both. Data will be generated from claims for NRT products and from client information provided by the Quit Line contractor.**

- Maintain birth rates among Plan First service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First Demonstration. G**oal-Maintain the overall birth rate of about 100 births per 1000 Plan First enrollees. The eligible population counts will be based on income and insurance coverage estimates made from surveys collected by the Census Bureau annually.**

- Increase the usage of the Plan First Waiver by making sterilizations available to males ages 21 years or older. **This goal will be evaluated based on the number of sterilizations performed statewide.**

The DY16 evaluation of goals has not been completed at this time. Please reference Attachment C for an evaluation of the DY15 goals.

III. Program Highlights

The Plan First Program has continued to function well with enrollment for the key participant group, women ages 20-29, including nearly all the women estimated to be eligible. Through Plan First, women are able to take advantage of all family planning and pregnancy prevention services and products offered through the Medicaid. These services include all types of contraceptives; pills, patch ring, diaphragms and LARC. Sterilizations are a covered service under the Plan First Program. Once a recipient is sterilized, the eligibility status will end and he or she is no longer eligible to receive services under the Plan First Program. Recipients are able receive physician office visits for family planning services, labs and STD screenings and counseling services.

Effective August 2015, males were added as a covered eligibility group for vasectomy and vasectomy related services only. In November 2016, Medicaid submitted an amendment to CMS to add care coordination for males as a covered service. The proposed change to the overall

demonstration will assist males with establishing Medicaid, locating the appropriate doctor to perform the procedure and assist with making and keeping appointments for initial consultations and follow-up visits.

Medicaid is also anticipating that the added service will increase male enrollment in Plan First for vasectomies and vasectomy related covered services by 10% annually. An anticipated goal is that 85% of male Plan First enrollees will receive care coordination services and 75% of male enrollees will undergo the procedure within the enrollment year.

Effective for dates of service October 1, 2012, selected smoking cessation products are covered for Medicaid recipients on the Plan First Program. Prior authorization is not required for Plan First recipients. Medicaid will provide Nicotine Replacement Therapy (NRT) products such as nicotine patches, nicotine gum, nicotine lozenges, bupropion tablets and varenicline tablets and counseling through ADPH's Quitline to Plan First Eligible women who show readiness to quit using tobacco products.

Any qualified provider can enroll as a provider for the Plan First Program. Direct services are augmented with care coordination and tracking for "high risk" and "at risk" women to ensure compliance with the woman's chosen birth control method. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allows for enhanced contraceptive education on appropriate use of the chosen method, further assurance of correct and continued usage, and successful family planning with spacing of pregnancies.

Care coordination services are available to all female Plan First recipients. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning.

These services are provided by licensed social workers or registered nurses associated with the Department of Public Health. Services are available to all Plan First recipients, excluding males, regardless of the service provider. Should care coordination services be needed, a referral is made by calling the local health department and asking for the Plan First Care Coordinator. Male Plan First recipients are not eligible for care coordination at this time.

Care coordination may be provided separate and apart from the initial, periodic and/or annual visits. Face to face encounters are provided at the county health departments and in private physician offices. Other types of encounters include telephone, letter writing and postcards appointment reminders.

The goal of care coordination is to form a partnership with recipients to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial

issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.
- Consultation with providers regarding problems with the selected family planning method.

The care coordinator work diligently with family planning providers to ensure that recipients receive care coordination services in a timely manner. Services include a risk assessment to determine if a woman is at a high risk for an unintended pregnancy. If determined to be high risk then a bio-psychosocial assessment is conducted and a case plan developed for those women that accept services. Through the risk assessment process, counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified through the assessment, such as substance abuse or domestic violence are discussed and resources offered. General questions about family planning are also addressed with information provided through low-literacy family planning education based on the PT+3 model.

Once a woman accepts services, referrals and follow up will continue to ensure appointments are kept for family planning visits and acquisition of desired family planning method, as well as consultation with providers regarding problems with the selected family planning method.

IV. Reporting Schedule

Demonstration Year	Begin Date	End Date	Annual Report Due Date (90 days following end of Annual date)
15	January 1, 2015	December 31, 2015	March 31, 2015
16	January 1, 2016	December 31, 2016	March 31, 2016
17	January 1, 2017	December 31, 2017	March 31, 2017

V. Significant Program Changes

Effective January 1, 2015, coverage was added for eligible Plan First males ages 21 years or older for vasectomies and vasectomy related services.

VI. Enrollment and Renewal

The table below captures DY 16 enrollment figures for the following populations:

Population 1: Women losing Medicaid pregnancy coverage the conclusion of 60 days postpartum.

Population 2: Women 13-44 who have an income at or below 185 percent of the FPL.

Population 3: Men 13-44 who have family income at or below 185 percent of the FPL

	Demonstration Year 15 January 1, 2015 through December 31, 2015			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees	17,228	13,336	249	429,211
# of Participants	*	*	249	117,312♦
# of Member Months	49,722	36,756	1,102	1,079,346

	Demonstration Year 16 (January 1, 2016 through December 31, 2017)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees	11,774	9,799	477	385,579
# of Participants	*	*	477	91,661♦
# of Member Months	67,944	58,794	2,862	767,937

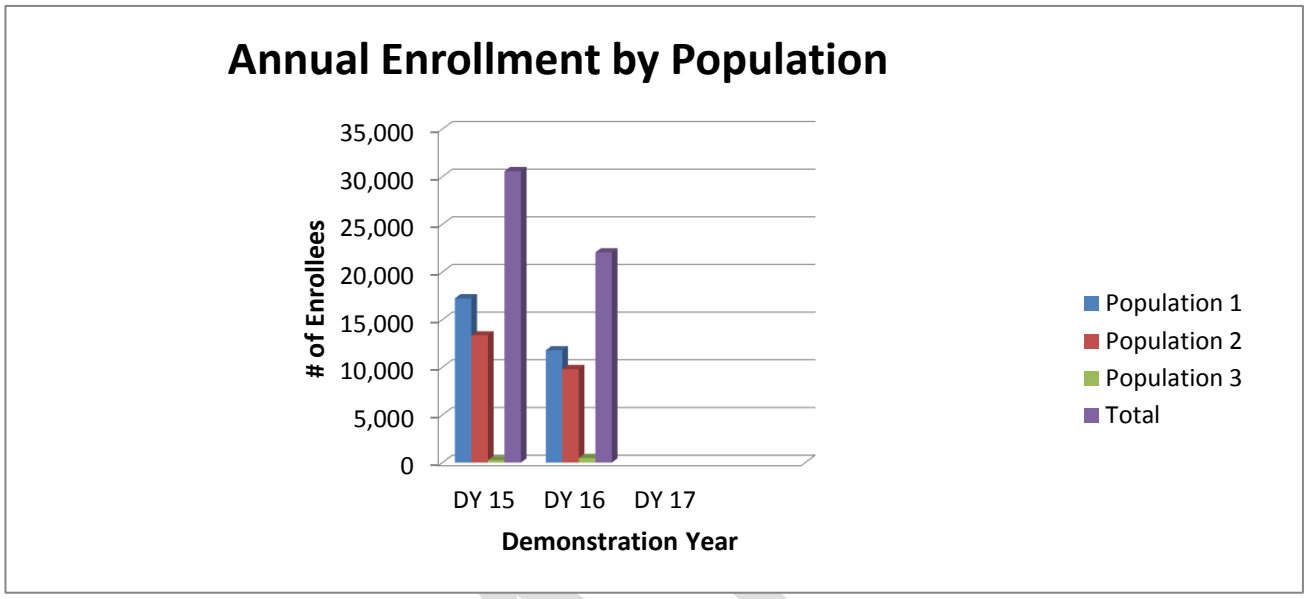
*****Currently Alabama Medicaid is unable to track Populations 1 & 2 ongoing as once a recipient "flips" from maternity to Plan First after the 60th postpartum day or is awarded Plan First coverage, they do not stay in that group and become part of the total population the following month – they do not stay in Population 1 (flips) or Population 2 (awards) ongoing. Likewise there is no mechanism for tracking which flips or awards are active participants, only the active participants for the total population. Alabama Medicaid is also unable to track those enrolled with Express-lane Eligibility ongoing as markers identifying those recipients are removed when matching with SNAP and TANF data.

♦Of the total population of eligibles, this is the number of recipients with a billable service during the quarter (active participants).

	Demonstration Year 17 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member				

Months				

Annual enrollment for DY 15 through DY 17:



Medicaid continues to conduct its quality assurance processes. Random samplings of recipient records are evaluated to ensure compliance with program requirements. This is in conjunction with regularly scheduled internal audits by the Alabama Department of Public Health. Ongoing Plan First Program evaluations also conducted through the University of Alabama at Birmingham School of Public Health.

In order to accomplish the Waiver requirements, the Agency implemented the following monitoring and quality functions:

- Review utilization reports from claims data to monitor trends and utilization
- Review care coordinator activity summary reports
- Review summary reports from UAB
- Monitor complaints and grievances to acceptable resolution.
- Built in claims system edits and audits to prevent duplication of payments

The University of Alabama at Birmingham conducts ongoing internal evaluations for this Demonstration Waiver. Their responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to the Alabama Medicaid Agency and the Department of Public Health on program operation and outcomes. With UAB's assistance, a yearly Demonstration progress report that illustrates progress, goal achievement, and other areas for continued improvement. UAB is not involved in direct patient care for the Plan First Program. Please reference the attached Annual Evaluation for DY 2015.

Record Reviews

Medicaid completed a random review of recipient records to determine if services were provided according to established guidelines. The following findings were identified:

- Providers were not documenting using the PT+3 model
- Providers were not documenting counseling activities

Education was provided to providers regarding the requirements of the Plan First Program.

The Alabama Department of Public Health Area supervisors audit Plan First care coordination patient records quarterly utilizing a standardized audit tool. These audits are submitted to the Public Health Central Office and are available for review by Medicaid. All care coordination patient records are documented electronically and the Central Office conducts an annual desk review of the patient records for each Care Coordinator, submitting a written report to supervisors. Six weeks after Care Coordinators complete certification training, the Central Office training staff reviews their documentation and submits a written report to their supervisor. The Public Health Program Integrity staff randomly reviews patient records in county health departments for compliance with travel reimbursement, billing of appropriate time for services, and ensuring that all time coded to Plan First has appropriate documentation to justify billing. A total of 3,104 audits were conducted by Medicaid's monitoring agency with a reported compliance rate of 99%.

The Medicaid Agency provides general quality oversight for the Plan First Program through direct monitoring and serves as the clearinghouse for other activities done in this area. Medicaid conducts random checks on enrollment and claims data. Budgets are monitored on an on-going basis, and any areas of concern are evaluated and referred for claims review as indicated.

Utilization Monitoring

Medicaid continues to monitor over-utilization and under-utilization of care coordination. To assist with monitoring, effective May, 2017, Medicaid will implement a policy and system change to add Procedure Codes to distinguish face to face encounters from other care coordination activities such as letter writing and postcard communications. Data will be reviewed quarterly to determine utilization and will be used to determine record review sampling.

Complaints and Grievances

Complaints and Grievance are tracked and monitored until resolution. Medicaid has not received any grievances from beneficiaries, providers or the public. No public hearing or other notice procedures were conducted during DY16.

Transition Plan

Effective January 1, 2014, Medicaid implemented a new policy on eligibility coverage groups such as Pregnant Women, Children under age 19, Family Planning, Parents and Other Caretaker Relatives, and Former Foster Care Children who were affected by the Affordable Care Act

(ACA) of 2010 (also known as Patient Protection and Affordable Care Act of 2010). The ACA mandates the use of Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for specific groups of Medicaid applicants and beneficiaries such as pregnant women, children under age 19, family planning, and parents and other caretaker relatives. The income amount for these women now goes up to 141% of the Federal Poverty Level. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

Award Public Forums

As a requirement of the Special Terms and Conditions, a six month Public Forum Hearing for input on Medicaid's Plan First 1115 Demonstration Waiver was held on July 21, 2016. A thirty (30) day public comment period was provided and the announced on Medicaid's website. Eight (8) people attended the hearing. See the Attachment A for all public comments.

As a requirement of the Special Terms and Conditions, an annual Public Forum Hearing for input on Medicaid's Plan First 1115 Demonstration Waiver was held on March 1, 2017. A thirty (30) day public comment period was provided and the announced on Medicaid's website. Six (6) people attended the hearing. See the Attachment B for all public comments.

VIII. Annual Expenditures

Medicaid is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. The chart below includes the expenditure data, as reported on the Form CMS-64 for DY 15 and DY 16.

	Service Expenditures as reported on the CMS-64		Administrative Expenditures as reported on the CMS-64		Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Total Computable	Federal Share		
DY 15	$34,504,758.94	$31,054,283.05	$180,231.88	$162,208.70	$36,759,039.00	$34,684,990.82
DY 16	$31,415,107.85	$28,273,597.07	$189,651.21	$170,686.09	$34,908,360.00	$31,604,759.06
DY 17						

	Demonstration Year 15 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months	$49,722.00	$36,756.00	$1,102.00	$1,079,346.00
PMPM	49.10	49.10	49.10	49.10
Total Expenditures *(Member months multiplied by PMPM)*	$2,441,350.20	$1,804,719.60	$54,108.20	$52,995,888.60

	Demonstration Year 16

	(fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months	$67,944.00	$58,794.00	$2,862.00	$767,937.00
PMPM	25.54	25.54	25.54	25.54
Total Expenditures *(Member months multiplied by PMPM)*	$1,735,289.76	$1,501,598.76	$73,095.48	$19,613,110.98

	Demonstration Year 17 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months				
PMPM				
Total Expenditures *(Member months multiplied by PMPM)*				

IV. Actual Number of Births to Demonstration Population

This number captures Plan First participants who received one or more covered family planning services between January 1, 2014, and December 31, 2015 and had an actual birth in DY15.

	# of Births to Demonstration Participants
Demonstration Year 15	**16,725**
Demonstration Year 16	
Demonstration Year 17	

X. Cost of Medicaid Funded Births

The average total Medicaid expenditures for DY 15 for a Medicaid-funded birth is noted below.

	Average total Medicaid expenditures for a Medicaid-funded birth
Demonstration Year 15	**FY 2015**
	Count ID_medicaid 24,781
	Contractor Paid $ 57,149,922.64
	Hospital Paid $ 60,840,999.41
	Total $ 117,990,922.05
	Average Paid $ 4,761.35
Demonstration Year 16	
Demonstration Year 17	

IX. Activities for DY 17

Pending the approval of care coordination for males on Plan First, Medicaid will update the Plan First Manuals and continue to collaborate with providers to publicize the new service for males ages 21 years and older.

Medicaid will continue striving to meet identified goals provide family planning services to all women and men eligible for coverage. Efforts will continue to improve access to services. Medicaid will collaborate with partnering agencies to explore and improve statewide outreach activities to recipients and potential enrollees, contacting women who have recently delivered by phone or mail to inform them of Plan First services. The Medicaid Maternity Care Program care coordinators will assist with these efforts by informing maternity recipients of the Plan First Program before and after delivery and facilitate referrals to Plan First care coordinators and smoking cessation services. Complaints and grievances will be accepted and evaluated by Medicaid and ADPH, with appropriate follow-up. Plan First providers will continue to receive education, updates and Medicaid program/policy issues through the "Provider Insider" and through "Alert" messages. Ongoing program evaluations will also continue through the University of Alabama at Birmingham School of Public Health.

XII. Updated Budget Neutrality Monitoring Worksheet

Reference the Attachment D below for the updated budget neutrality monitoring worksheet. The worksheet exhibits a decrease in the 2016 PMPM months compared to the 2015 PMPM months which resulted in a decrease in the PMPM cost. Medicaid anticipates that this decrease may be related to the changes in the federal poverty level as a result of the Affordable Care Act which resulted in more Plan First and SOBRA eligible recipients being eligible for full Medicaid benefits.

Attachment D

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
Medicaid Pop 1	**2012**	**2013**	**2014**	**2015**	**2016**	**5-YEARS**
TOTAL EXPENDITURES	40,057,737	41,344,489	38,224,716	31,809,996	27,315,612	$ 178,752,550
ELIGIBLE MEMBER MONTHS	1,149,592	1,277,918	1,301,043	1,194,096	1,069,348	
PMPM COST	$ 34.85	$ 32.35	$ 29.38	$ 26.64	$ 25.54	
TREND RATES						**5-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		3.21%	-7.55%	-16.78%	-14.13%	-9.13%
ELIGIBLE MEMBER MONTHS		11.16%	1.81%	-8.22%	-10.45%	-1.79%
PMPM COST		-7.15%	-9.19%	-9.33%	-4.11%	-7.47%
						89,112

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	TOTAL WOW
Medicaid Pop 1										
Pop Type:	Medicaid									
Eligible Member Months	-1.8%		1,069,348	-1.8%	1,050,567	1,031,762	1,013,293	995,155	977,342	
PMPM Cost	0.0%	0	$ 25.54	0.0%	$ 26.01	$ 26.01	$ 26.01	$ 26.01	$ 26.01	
Total Expenditure					$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	TOTAL WW
Medicaid Pop 1								
Pop Type:	Medicaid							
Eligible Member Months	1,069,348	-1.8%	1,050,567	1,031,761.53	1,013,293.00	995,155.05	977,341.78	
PMPM Cost	$ 25.54	0.0%	$ 26.01	$ 26.01	$ 26.01	$ 26.01	$ 26.01	
Total Expenditure			$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2017	2018	2019	2020	2021	
Medicaid Populations						
Medicaid Pop 1	$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2016	2017	2018	2019	2020	
Medicaid Populations						
Medicaid Pop 1	$ 27,327,762	$ 26,836,117	$ 26,355,751	$ 25,883,983	$ 25,420,660	$ 131,824,273

Note 1:	Used the historic expenditures and member months from 2012-2016
Note 2:	Added 30 eligible males to approximate member months in DY 2017
Note 3:	Added $12,150 to the total projected total expenditures in DY2017 and calulated the PMPM by dividing total expenditure by eligible member months
Note 4:	Changed PMPM trend rate to 0%