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

The name of the waiver program is Prepaid Mental Health Plan (PMHP). (Please list each program name if the waiver authorizes more than one program.)

Type of request. This is an:
___ initial request for new waiver. All sections are filled.
___ amendment request for existing waiver, which modifies Section/Part ____
__ Replacement pages are attached for specific Section/Part being amended (note:
the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
__ Document is replaced in full, with changes highlighted
_x__ renewal request
x 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.
__ The State has used this waiver format for its previous waiver period. Sections
C and D are filled out.
Section A is ___ replaced in full
___ 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 ___ replaced in full
___ carried over from previous waiver period. The State:

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

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

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective January 1, 2006 and ending December 31, 2007. (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 Julie Olson and can be reached by telephone at (801) 538-6303 or fax at (801) 538-0156, or e-mail at julieolson@utah.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

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

Staff periodically attend the Division of Health Care Financing's (DHCF's) Utah Indian Health Advisory Board meetings to provide information on the PMHP and obtain feedback and comment. In a recent meeting, the tribal representatives were given a brochure that explains the Prepaid Mental Health Plan and were encouraged to contact the PMHP program manager any time they have questions, concerns about a specific provider, etc. Bureau of Managed Care staff has been invited back to give a more in-depth presentation on the PMHP as several board members are new.

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).

The Division of Health Care Financing ,Utah's Medicaid agency, in the Utah Department of Health (UDOH), administers the Medicaid program. Utah has operated a waiver program called the Prepaid Mental Health Plan (PMHP) since July 1, 1991, in selected areas of the State.

The overall objective of the PMHP is to maximize the contractors' flexibility to effectively and responsibly use Medicaid funds to ensure Medicaid enrollees have access to mental health services and to improve mental health outcomes for Medicaid clients.

During this waiver period, DHCF continued to contract with nine community mental health centers (four urban and five rural) to provide all inpatient and outpatient mental health services to Medicaid enrollees, either directly or through arrangements with subcontractors. Approximately 98 percent of Utah Medicaid clients are enrolled in the PMHP. Only two rural counties, Wasatch and San Juan, are not covered under the PMHP.

All Medicaid enrollees, with the exception of individuals at the Utah State

Hospital and the Utah Developmental Center, are automatically enrolled in the PMHP that serves their area.

Medicare dual eligibles are also enrolled in the PMHP . However, they are not limited to the PMHP for mental health services. If they so choose, they may obtain mental health services from any qualified Medicare provider. The Medicaid portion of the provider claims are processed and paid through the Medicaid crossover system as PMHP premiums are net of third party liability.

As of July 1, 1995, children in State custody (foster care) are enrolled in the PMHP only for inpatient psychiatric services. They may receive outpatient mental health services from any qualified Medicaid provider. Medicaid enrollees with adoption subsidy may be exempted from the PMHP on a case-by-case basis for outpatient mental health care. This is based on legislation passed in the State's 2001 general legislative session that allowed adoption subsidy children to receive outpatient mental health services outside of a capitated system. As with children in state custody, contractors receive inpatient premiums for these exempted adoption subsidy children. Medicaid enrollees selecting the HOME program are disenrolled from the PMHP for the duration of their enrollment in HOME. The PMHP contractor receives no premium for HOME enrollees.

A. Statutory Authority

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

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

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

c. 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

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

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

a. x___ Section 1902(a)(1) - State-wideness--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.___ 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.___ Other Statutes and Relevant Regulations Waived - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

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

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

b. x__PIHP: Prepaid Inpatient Health Plan means an entity that:
(3) 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.

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

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

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

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

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

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

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

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

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)

x___ **Sole source** procurement

___ **Other** (please describe)

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

1. Assurances.

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

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

Enrollees are automatically enrolled with the PMHP contractor serving their county of residence. PMHP contractors have the flexibility to provide services directly or through subcontracts with other community providers. Enrollees may request authorization to receive services from a private practitioner (either a PMHP subcontractor or a non-panel, non-subcontracted provider). Contractors are required to follow the BBA service authorization requirements for processing requests for initial or ongoing services with requested providers. If the request is denied, the enrollee may file an appeal of the decision in accordance with BBA regulations. Therefore, the contractors' flexibility for subcontracting with community practitioners and the BBA service authorization and appeal provisions help mitigate the effect lack of choice of plan could have.

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.
___ Other: (please describe)

3. Rural Exception.

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

4. 1915(b)(4) Selective Contracting

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

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

. Geographic Areas Served by the Waiver

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

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

x___ Less than Statewide
San Juan and Wasatch counties are not included in the Prepaid Mental Health Plan. Mental health centers serving these two counties provide mental health services on a fee-for-service basis. (See map of PMHP coverage in Appendix A.1.D)

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.

Counties	Name of Entity	Type of Program
Box Elder, Cache, Rich	Bear River Mental Health	PIHP
Juab, Millard, Sanpete, Sevier, Piute, Wayne	Central Utah Mental Health	PIHP
Davis	Davis Behavioral Health	PIHP
Carbon, Emery, Grand	Four Corners Community Behavioral Health	PIHP
Beaver, Garfield, Iron, Kane, Washington	Southwest Behavioral Health Center	PIHP
Salt Lake, Summit, Tooele	Valley Mental Health	PIHP
Utah	Wasatch Mental Health	PIHP
Morgan and Weber	Weber Human Services	PIHP
Duchesne, Daggett, Uintah	Northeastern Counseling Center	PIHP

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

___ Section 1931 ~~Adults and Related Populations are adults including those eligible under Section 1931,~~ poverty-level pregnant women ~~and optional group of caretaker relatives.~~
See #2. "Excluded Populations," "other," below.

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.
(Children in state custody are enrolled for inpatient psychiatric care only)

x___ Mandatory enrollment
___ Voluntary enrollment

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

___ 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:

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

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

___ Other Insurance--Medicaid beneficiaries who have other health insurance.

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

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

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

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

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

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

x___ SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

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

x___ Other (Please define):

Individuals in the 1115 Demonstration Project:

Section 1931 non-pregnant adults age 19 and older and related poverty level population; and

Individuals age 19 and older who qualify for Medicaid by paying a spenddown and who are not aged or disabled.

Also, individuals residing in the Utah State Hospital or the Utah Developmental Center; and

Enrollees whom the State disenrolls on a case-by-case basis due to HOME Program selection.

F. Services

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

1. Assurances.

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

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

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

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

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

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

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections

1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

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

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

___The PIHP, PAHP, or FFS Selective Contracting program does not cover
emergency services.

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

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

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

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

___ Other (please explain):

x___ Family planning services are not included under the waiver.

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

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

PMHP contractors are required to attempt to subcontract with the FQHC serving their coverage area.
Valley Mental Health, Central Utah Counseling, Weber Human Services and Southwest Behavioral Health have subcontracts with FQHCs in their catchment areas.

In Valley's subcontract with Wasatch Homeless Health Center, the agreement provides for Valley Mental Health to co-locate clinical staff at the FQHC and for the FQHC to deploy medical staff to Valley's Safe Haven, a program for homeless mentally ill. This is an excellent way to coordinate and ensure continuity of mental health and physical health care.

Bear River has two FQHCs its catchment area. In Rich County, a small rural county, the FQHC and Bear River are co-located in the same building with Bear River providing the mental health services. In Box Elder County, Bear River currently is in the discussion phase with the FQHC regarding a subcontract.

Four Corners has agreements with the three FQHCs in its coverage area to provide mental health services onsite at the FQHCs. Wasatch has attempted to subcontract with the FQHC in its catchment area. This FQHC's Medicaid clientele are reportedly a small percentage of its overall clientele and generally the FQHC has referred clients to Wasatch Mental Health for services (both agencies are in close proximity and have a good working relationship) or the FQHC has provided services using its own staff.

Also, FQHCs or enrollees can request authorization to provide or get services from the FQHC. The PMHP contractors would follow the BBA-required service authorization policies and protocols that are contained in Article IX of the PMHP contract.

___ The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as

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

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

5. EPSDT Requirements.

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

6. 1915(b)(3) Services.

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.

All enrollees receiving services from the PMHP contractors are eligible for 1915(b)(3) services depending on individual need/medical necessity. PMHP contractors receive monthly premiums that are comprised of a State Plan services component and a 1915(b)(3) services component. See Section D, Cost Effectiveness, Part I, H., "Chart: Renewal/Conversion Waiver State-Specific 1915(b)(3) Service Expenses and Projections."

Currently approved 1915(b)(3) services include:

Psychoeducational Services

Psychoeducational Services are recommended by a physician or practitioner of the healing arts (licensed mental health therapist) and are furnished for the

primary purpose of assisting in the rehabilitation of enrollees with serious and persistent mental illness or serious emotional disorders. This rehabilitative service includes interventions which help clients achieve goals of remedial and/or rehabilitative educational and vocational adequacy necessary to restore them to their best possible functioning level.

Personal Services

Personal Services are recommended by a physician or practitioner of the healing arts (licensed mental health therapist) and are furnished for the primary purpose of assisting in the rehabilitation of the individual client with serious and persistent mental illness or serious emotional disorder. These services include assistance with *instrumental* activities of daily living (IADLs) that are necessary for individuals to live successfully and independently in the community and avoid hospitalization. Personal services include assisting the client with varied activities based on the client's rehabilitative needs, such as: picking up prescriptions, banking and paying bills, maintaining the living environment including cleaning and shopping, and the transportation related to the performance of these activities, and representative payee activities when the mental health center has been legally designated as the client's representative payee. These services assist enrollees to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

Respite Care

This service is recommended by a physician or practitioner of the healing arts (licensed mental health therapist) and is furnished for the primary purpose of assisting in the rehabilitation of children with serious emotional disorders. This rehabilitative service helps the client achieve his/her remedial and/or rehabilitative treatment goals by giving parents respite from the challenges of caring for a mentally ill child. Without respite, parents may be at risk for neglect or abuse of the child, particularly if they suffer from a mental illness themselves. Respite care is provided for the primary purpose of giving parent(s) temporary relief from the stresses of caregiving to a mentally ill child so that they are better able to interact in appropriate ways that are not counter-therapeutic to the child's achievement of his/her remedial and/or rehabilitative goals. During the provision of this service, staff have a therapeutic focus with the child. Therefore, this service is provided in tandem with the child's other mental health treatment services and also assists the child to achieve his/her rehabilitative goals and to be restored to his/her best possible functioning level.

Supportive Living

Supportive living costs include the costs for 24-hour staff and room and board in residential treatment/support programs but not the costs of providing Covered

Services. Medicaid Enrollees are placed in these programs in lieu of inpatient hospitalization so that they may remain in a less restrictive community environment and still receive the therapeutic structure, monitoring, observation and support services they would receive in the hospital. This level of care is recommended by a physician or other practitioner of the healing arts (mental health therapist), and helps restore clients with serious and persistent mental illness or serious emotional disorders to their best possible functioning level. Staffing may consist of a combination of licensed mental health therapists, licensed medical providers and licensed and unlicensed paraprofessionals (e.g, licensed social service workers, unlicensed human service technicians, etc.)

Proposed 1915(b)(3) services:

The State requests approval of the following 1915(b)(3) services. The State intends that PMHP contractors may use savings deposited in their community reinvestment funds to provide these services based on CMS approval of their individual community reinvestment fund proposals:

Peer Support Services

Peer Support Services are recommended by and furnished under the direction of a physician or practitioner of the healing arts (licensed mental health therapist). These services are for the primary purpose of assisting in the rehabilitation and recovery of enrollees with serious and often persistent mental illness (SPMI). These services may be provided to an individual or a group of individuals and are provided by peers who have been trained by the contractor to provide supportive services. These services are designed to assist enrollees optimize their overall level of community integration, cope effectively with their mental illnesses, increase medication adherence, and help them establish or enhance meaningful relationships that have been adversely impacted by their mental illness. Peer providers offer a unique perspective that clients find credible, builds alliances and instills hope, demonstrating that recovery is possible. This service also includes peer training and ongoing supervision of paid peers by the contractor's clinical staff.

Peer Advocacy Services

Peer Advocacy Services are provided to enrollees or their family members (e.g., parent of a child enrollee with serious emotional disorder) to provide support and advocacy as enrollees pursue self-directed care. This service also includes peer advocate training and ongoing supervision of peer advocates by the contractor's clinical staff. This service also includes peer training and ongoing supervision of paid peer advocates by the contractor's clinical staff.

Family Education/Training

Family Training means courses for families of children with mental illness or serious emotional disturbance to provide current information about mental illness and serious emotional disorders, to help families learn general strategies for managing their children's symptoms and behaviors, and to help families learn how to give support to their family member.

Training Services

Training Services include a broad array of trainings directed to the contractor's clinical staff, enrollees' family members/significant others, community stakeholders, and enrollees.

Trainings include:

1) NAMI Bridges - NAMI staff educate the contractor's clinical staff on mental illness from a client and family perspective which then fosters client-directed services

2) NAMI Family-to-Family program- NAMI staff provide education and support to SPMI enrollees' family members and significant others

3) Contractor clinical staff providing training to other entities that provide non-mental health services to enrollees. Examples include training to school personnel to increase understanding of mental illness and strategies for handling behaviors related to enrollees' mental illness in the school setting, training to physical health care providers on mental illness, integration and coordination of physical and mental health care. Trainings can also be provided to other groups in a variety of community settings, such as schools, churches, senior citizen centers, etc., with the goal of increasing awareness and understanding of mental illness, prevention and early detection of mental illness, and decreasing stigma related to mental illness

4) Employment Personal Assistant Service (E-PAS)-- This training service is two-fold:

a. Contractor staff train the enrollee's selected E-PAS provider to provide assistant services to the enrollee on-the-job so that the enrollee successfully manages his mental illness and maintains his employment, and

b. Contractor staff train the enrollee on being an employer of an Employment Personal Assistant.

Training Services costs include costs associated with training materials, which may include technology such as e-learning modules and e-access programs, and for E-PAS training provided by contractor clinical staff.

7. Self-referrals.

NA The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following

circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):
4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ In-Office Waiting Times: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ Other Access Standards (please describe)

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

B. Capacity Standards

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

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

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

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

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

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

a.___ The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b.___ The State ensures that there are adequate number of PCCM PCPs with open panels. Please describe the State's standard.

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

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

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

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

e.___ The State ensures adequate geographic distribution of PCCMs. Please describe the State's standard.

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

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___Other capacity standards (please describe):

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

Mental health services are carved out of the Choice of Health Care Delivery waiver and are provided by specialized mental health providers (PMHP contractors). Therefore, all enrollees getting mental health services have special (mental) health care needs. All mental health clients receive an individualized comprehensive mental health evaluation by a licensed mental health therapist and are prescribed a mental health treatment plan. Mental health clinicians or case managers are responsible to coordinate their clients' mental health care with their physical health care

providers when indicated. Therefore, the mental health population as a carve-out is a special needs population in and of itself.

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

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

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

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

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

3.__ In accord with any applicable State quality assurance and utilization review standards.

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

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

a. ___ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.

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

c. ___ Each enrollee ~~is~~ receives health education/promotion information. Please explain.

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

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

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

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

___ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on August 13, 2003.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	All nine PMHP contractors		Validation of performance improvement projects, validation of performance measures and contract compliance monitoring (42 CFR 438.358(b)(1)	Validation of encounter data (438.358(c)(1)

2. Assurances For PAHP program.

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

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

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

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please

note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality improvement guidelines for its PCCM program. Please attach.

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

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ Selection and Retention of Providers: This section provides the State the opportunity to describe any requirements, policies or procedures

it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

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

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ Other quality standards (please describe):

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

NA 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.

Not applicable; PMHP enrollment is mandatory. Enrollees are automatically enrolled with the contractor serving their county of residence.

_____ 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.

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

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

2. Details

a. Scope of Marketing

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

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

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

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

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

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

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

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

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

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

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

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

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

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

2. Details.

a. Non-English Languages

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

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

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. x The languages spoken by approximately 5 percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

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

The PMHP contract requires contractors to provide oral interpretation services free of charge to each enrollee needing interpretation services. All contractors have clinical staff who speak Spanish, and interpreter organizations are available to provide services in person and/or telephonically.

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

At the time of Medicaid enrollment, eligibility workers or health program representatives are responsible to ensure enrollees receive the DHCF's Exploring Medicaid booklet and a copy of the applicable PMHP contractor's Medicaid Member Handbook. Exploring Medicaid includes basic information about Medicaid and managed care. Until September 2005, there were urban and rural versions of Exploring Medicaid. With the expansion of physical health plans into the rural areas of the State, two versions were no longer needed. Beginning in September 2005, there is a consolidated version of Exploring Medicaid that covers both urban and rural areas. This booklet is available in English and Spanish and is currently being translated into braille. The information in this booklet on the PMHP is applicable to both urban and rural areas. (Appendix A. IV. B includes Exploring Medicaid and PMHP contractors' Medicaid Handbooks.)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

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

c. Enrollee Information

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

(i) x the State
(ii) x State contractor (please specify):

When enrollees begin receiving mental health services, PMHP contractors give them another copy of their Medicaid Member Handbook.

(ii) ___ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

C. Enrollment and Disenrollment

1. Assurances.

NA 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.

42 CFR 438.56 is not applicable to this program.

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

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

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

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

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

b. Administration of Enrollment Process.

___ State staff conducts the enrollment process.

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

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

Broker name: _____

Please list the functions that the contractor will perform:

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

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

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

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

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

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

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

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

x___ The State automatically enrolls beneficiaries

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

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

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

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

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

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

d. Disenrollment:

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

i.___ Enrollee submits request to State.

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

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

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

Disenrollment in general from the PMHP is not permitted. If enrollees eligible for the HOME Program select this program, the State disenrolls them from the PMHP. If subsidized adoptive children are exempted from the PMHP for outpatient services, they are enrolled only for inpatient care.

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

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

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

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

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

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

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

D. Enrollee rights.

1. Assurances.

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

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

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

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

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

E. Grievance System

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

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

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

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

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

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

b. **Timeframes**

___ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days (between 20 and 90).

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

There is no timeframe required by the State time during which Enrollees must file a grievance BBA regulations also have no specified time frame requirements for filing grievances.

c. **Special Needs**

NA 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.

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

___ The grievance procedures is operated by:

- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

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

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

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

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

___ Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

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

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

___ Other (please explain):

F. Program Integrity

1. Assurances.

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

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

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

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

___ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

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

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

Section B: Monitoring Plan

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

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(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 *NA due to auto-enroll-ment*	Marketing *NA due to auto-enrollment*	Enroll/ Disenroll *NA due to auto-enroll-ment*	Program Integrity	Information to Bene-ficiaries	Grievance	Timely Access	PCP/ Spec. Capacity	Co-ordination /Continuity	Coverage / Author-ization	Provider Selection	Quality of Care
Accreditation for Non-duplication *NA*												
Accreditation for Participation *NA*												
Consumer Self-Report data							x					x
Data Analysis (non-claims)						x						
Enrollee Hotlines				x	x	x	x	x	x	x	x	x
Focused Studies *NA*												
Geographic												

mapping								x				
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice *NA due to auto-enroll-ment*	Marketing *NA due to auto-enrollment*	Enroll/ Disenroll *NA due to auto-enroll-ment*	Program Integrity	Information to Bene-ficiaries	Grievance	Timely Access	PCP/ Spec. Capacity	Co-ordination /Contin-uity	Coverage / Author-ization	Provider Selection	Quality of Care
Network Adequacy Assurance by Plan *NA*												
Ombudsman				x	x	x	x	x	x	x	x	x
On-Site Review					x	x	x	x	x	x	x	x
Performance Improvement Projects							x		x			
Performance Measures							x					
Periodic Comparison of # of Providers								x				
Profile Utilization by Provider Caseload								x				

Provider Self-Report Data				x								x
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice *NA due to auto-enroll-ment*	Marketing *NA due to auto-enrollment*	Enroll/ Disenroll *NA due to auto-enroll-ment*	Program Integrity	Information to Bene-ficiaries	Grievance	Timely Access	PCP/ Spec. Capacity	Co-ordination /Continuity	Coverage / Author-ization	Provider Selection	Quality of Care
Test 24/7 PCP Availability							x					
Utilization Review										x		

II. Details of Monitoring Activities

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

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

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

a. NA____ 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)

PMHP contractors are not accredited by these any of these organizations.

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

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

PMHP contractors are not accredited by these any of these organizations.

c. x_____ Consumer Self-Report data

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

Applicable program: PMHP waiver

Personnel responsible: State Medicaid agency and Division of Substance Abuse and Mental Health (DSAMH)

Detailed description of the activity:

Activity #1:

PMHP contractors participate in a state-wide consumer survey initiative sponsored by the DSAMH, and supported by DHCF, to assess mental health center clients' satisfaction and mental health outcomes. Rather than developing a state survey, the stakeholders evaluated a variety of nationally recognized and tested satisfaction and outcomes instruments for behavior health and agreed on certain instruments for this state-wide project.

For adult clients, the mental health centers use the Mental Health Statistical Improvement Project (MHSIP) instrument. The MHSIP has domains on general satisfaction, access, quality and improvement and perceived outcomes.

For adolescents ages 12-18, stakeholders selected the Youth Satisfaction Survey (YSS) and the YSS-F, the version for parents/guardians to complete on their perceptions of the youth's treatment. (Appendix B.II contains copies of these instruments.)
Frequency of use: The MSHIP, the YSS and YSS-F are administered annually during a DSAMH-specified month. Clients who come in for services during that specified month are given the applicable survey to complete. Clients complete the surveys while at the center. The completed MHSIP, YSS and YSS-F surveys are submitted to the DSAMH for compilation and analysis. The DSAMH submits reports back to the mental health centers and to DHCF annually.
How it yields information about the areas being monitored: The instruments address broad domains which are also areas monitored under the PMHP: general satisfaction, access, quality and outcomes of care.

Activity #2:
The Bureau of Managed Health Care staff also takes client complaints that come directly to the bureau. Sources include Medicaid enrollees, providers, Bureau of Managed Health Care's health program representatives (HPRs), eligibility workers, etc.
Frequency of use: Ongoing

How it yields information about the areas being monitored: Questions and complaints give State staff information about the types of concerns enrollees or others have regarding the PMHP (e.g, access, quality, policy, coverage, etc.) and allow State staff to work with contractors as needed to resolve.

d. x_____ Data Analysis (non-claims)

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

Applicable program: PMHP waiver
Personnel responsible: State Medicaid agency and EQRO
Detailed description of activity: PMHP contractors are required to process grievances and appeals in accordance with BBA managed care requirements that have been incorporated into Article X, Grievance Systems, of the PMHP contract.

Activity #1:
The State contracts with an EQRO, Health Services Advisory Group (HSAG), to conduct the mandatory EQR activities. In accordance with 42 CFR 438.358(b)(3), HSAG conducted PMHP contract compliance reviews to determine if contractors have implemented the BBA managed care regulations. Contract compliance reviews included a review of the contractors' grievance systems to determine if they have implemented grievance system requirements specified in 42 CFR 438.228, and 42 CFR 438.400-438.424 (Subpart F). HSAG conducted grievance systems reviews through pre-onsite desk audits of grievance system policies and procedures and onsite reviews at each PMHP contractor. As part of their review protocol, they sampled grievances and appeals to determine if the contractors had complied with policies and procedures and had met the required time frames for processing them.

Activity #2:
The contractors submit semi-annual reports to the State Medicaid agency of grievances and appeals received during the preceding six month period (January through June and July through December).

Frequency of use: Review of contractors' overall grievance systems by HSAG will be conducted in accordance with 42 CFR 438.358(b)(3). The State reviews contractors' grievance and appeals reports semi-annually.

How it yields information about the area(s) being monitored: EQR required under 42 CFR 438.358(b)(3) gives information about contractors' ongoing compliance with grievance system requirements.

Semi-annual grievance reports to the State provide information on types of grievances (e.g., quality of care, accessibility, satisfaction issues, etc.), timeliness of resolution, resolution status, and whether there are trends or systemic issues contractors should address.

Semi-annual appeals reports to the State provide information on number of appeals, type of action being appealed an d resolution (i.e., whether in enrollee's favor, whether continuation of benefits was involved, number going to State fair hearing, outcome of State fair hearing and whether enrollees were held liable for cost of services that were continued during the appeal or State fair hearing process).

e. _x__ Enrollee Hotlines operated by State

Applicable program: PMHP waiver

Personnel responsible: State Medicaid agency

Detailed description of activity: The Medicaid agency's Customer Service Unit takes calls from Medicaid recipients, providers, etc. Customer Service staff forward individuals with PMHP-related questions or complaints to Bureau of Managed Health Care staff for assistance. Bureau staff answer questions, and in the case of complaints, work with the complainant and the contractor until the issue is resolved.

Frequency of use: Ongoing

How it yields information about the areas being monitored: As stated under "Self-Report Data" above, questions and complaints provide information about the types of concerns enrollees or others have regarding the PMHP and allow State staff to work with contractors as needed to resolve.

f. _NA____ 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).

The State requires the contractors to conduct PIPs in accordance with QAPI programs requirements found at 42 CFR 438.240(d), rather than focused studies. Also, 42 CFR 438.358(c)(5) describes an optional EQRO activity as "studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time." This is an optional EQRO activity that the State has not contracted with HSAG to conduct. Instead, HSAG annually validates the contractors' clinical and non-clinical PIPs using CMS' PIP validation protocol. HSAG also provides technical assistance to the PMHP contractors as they design and implement their PIPs.

g. x_____ Geographic mapping of provider network
Applicable program: PMHP waiver
Personnel responsible: Contractors and State Medicaid agency
Detailed description of activity: The contractors and the State complete a service delivery grid that is organized by county and provides information on covered services available by county and clinic site for adults and for children.
Frequency of use: The State Medicaid agency and contractors complete this grid and discuss service delivery layout at the time of the State's site visits during each waiver period.
How it yields information about the areas being monitored: This gives the State information on capacity and access by providing specific information about each contractor's service delivery and array of services available in the counties within their coverage areas.

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

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

The MHSIP, YSS and YSS-F survey instruments have items on cultural sensitivity. See "Consumer Self-Report" section above.

j. NA _____ Network adequacy assurance submitted by plan

[Required for MCO/PIHP/PAHP]

This requirement is due before a new contract is executed with the PIHPs (PMHP contractors). As required in 42 CFR 438.207(c), the State will submit each PMHP contractor's assurance of network adequacy prior to July 1, 2006, at which time new contracts will be in place.

HSAG's contract compliance reviews included evaluation of the contractors' capacity and access to provide covered services. In HSAG's Compliance Monitoring reports for each contractor, see Section C, Monitoring Results, Monitoring Activity, Onsite review, Evaluation of Access: Service/Specialist Capacity.

_____ Ombudsman

pplicable programs: PMHP waiver

ersonnel responsible: State Medicaid agency

Detailed description of activity: The Medicaid agency has a Constituent Services Representative who takes calls about any Medicaid-related issue (e.g., general Medicaid policy and coverage questions, concerns about access and quality of care, eligibility or billing questions or problems, etc.) For PMHP-related calls, the representative resolves the issues whenever possible. When necessary, she also refers PMHP-related questions or complaints to the Bureau of Managed Health Care staff to address.
Frequency of use: Ongoing
How it yields information about the areas being monitored: As stated under "Consumer Self-Report Data," and "Enrollee Hotlines operated by State," these calls give Bureau of Managed Health Care staff information on the types of issues that are occurring and the opportunity to work with the affected contractor(s) to identify areas for improvement and make needed changes.

_____ On-site review

Applicable programs: PMHP waiver
Personnel responsible: State Medicaid agency and EQRO (HSAG)

Detailed description of activity: HSAG used onsite reviews to conduct evaluations of PMHP contract compliance in accordance with 42 CFR 438.358(b)(3). They also conducted performance measures validation activities during their onsite reviews in accordance with 42 CFR 438.358(b)(2). The State also used onsite reviews for its monitoring during this waiver period.
Frequency of use: During contract compliance reviews in accordance with 42 CRF 438.358(b)(3) and during waiver periods
How it yields information about the areas being monitored: This monitoring approach gives the EQRO and the State the opportunity to obtain information in all areas: program impact, access and quality. The reviewers are able to obtain and review data and documents directly with the contractors, conduct interviews to elicit verbal information about policies and procedures, understanding of BBA regulations, etc. It also provides the opportunity for discussion of contractors' questions, PMHP contract provisions and for provision of policy clarifications, immediate feedback in exit conferences, etc.

x____ Performance Improvement projects [Required for MCO/PIHP]

x___ Clinical
x__ Non-clinical
Applicable programs: PMHP waiver
Personnel responsible: State Medicaid agency and EQRO
Detailed description of activity: In accordance with 42 CFR 438.358(b)(1), the EQRO conducts annual validation of the contractors' clinical and non-clinical PIPs. HSAG, with State involvement, also provides technical assistance as needed to ensure the contractors have sound project designs and are implementing the PIP activities correctly accordingly to the CMS protocol for conducting PIPs.
Frequency of use: Annual PIP validation activities
How it yields information: The validations provide information on the steps or activities of the PIP that occurred during the preceding 12 months, problems identified with implementing the steps, as well as information on PIP findings and improvements that are occurring as a result of the PIP. PIPs yield specific detailed information for the State on clinical and non-clinical aspects of the contractor organizations. PIPs are an excellent mechanism for ensuring that there are continual quality improvement initiatives.

n. x_____ 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

Applicable programs: PMHP waiver
Personnel responsible: The State Medicaid agency and the EQRO
Detailed description of activity: In accordance with 42 CFR 438.358(b)(2), the EQRO conducts annual validation of the contractors' performance measures that were reported to the State for the preceding calendar year. The contractors have access performance measures for providing first face-to-face services for emergent, urgent and non-urgent care.
Frequency of use: Contractors submit annual reports to the State summarizing performance on the measures for the preceding calendar year. The EQRO conducts an annual validation of the reported performance data.
How it yields information: The validation activities give information to the State on the validity of the performance reported to the State. Performance measures data give the State specific access-related information to assist in the State's oversight of access under the waiver.

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

Applicable program: PMHP waiver
Personnel responsible: State Medicaid agency
Detailed description of activity: Contractors submit clinician capacity data annually, as of July 1 each year. The reports include information on the numbers of FTEs, both total, vacant and filled FTEs. The data are separated out by type of clinical providers: physicians; other prescribers such as advanced practice registered nurses and physician assistants; licensed mental health therapists including psychologists, clinical social workers, marriage and family therapists, professional counselors; registered and licensed practical nurses; and other direct care staff such as licensed social service workers and case managers who are not licensed in one of the aforementioned categories. The data are provided by county

and separately for adult services staff, and for children's services staff, if there are separate teams.

Because the waiver was implemented in 1991, the State no longer compares number and types of providers after the waiver to before the waiver. From the data, the State prepares clinician-to-enrollee ratios for comparison purposes.
Frequency of use: Annually
How it yields information about the areas being monitored: The clinician capacity data assist the State in monitoring access and capacity to provide covered services to enrollees.

p. x____ Profile utilization by provider caseload (looking for outliers)
Applicable program: PMHP Waiver
Personnel responsible: State Medicaid agency
Detailed description of activity: For the PMHP, *provider* caseload is defined as *contractor* caseload or utilization. Using PMHP encounter data, the State calculates penetration rates for each contractor.
Frequency of use: Annually
How it yields information about the areas being monitored: The data yields contractor utilization and allows for comparisons among contractors. Penetration rates help the State to monitor access.

q. x____ Provider Self-report data

___ Survey of providers
___ Focus groups
x__ Other

Applicable program: PMHP waiver
Personnel responsible: Contractors and State Medicaid agency
Detailed description of activity:
Activity #1:
Annually, contractors submit self-report data on cultural competency initiatives during the preceding state fiscal year and those planned for the upcoming state fiscal year.

Activity #2:
Annually, contractors submit self-report data on the number of complaints of fraud and abuse that warranted preliminary investigation. When the preliminary investigation gives the contractor evidence that an incident of fraud or abuse has occurred,

contractors are required to conduct full investigations. Contractors submit reports of full investigations at the time of the investigation.

Frequency of use: Annually and ongoing
How it yields information about the areas being monitored:
Activity #1: These reports give information on contractors' efforts to attract culturally diverse staff and on educational and clinical activities that in turn affect quality of care.
Activity #2: This report provides information on any program integrity issues.

r. x_____ Test 24 hours/7 days a week PCP availability
Applicable program: PMHP waiver
Personnel responsible: State Medicaid agency
Detailed description of activity: Contractors do not have PCPs but they are responsible to provide 24 hour/7day-a-week crisis (emergency) services. Medicaid staff calls each contractor's after-hours service to determine if numbers are correct, directions on getting crisis services from the on-call crisis worker are clear and accurate, etc.
Frequency of use: Annually
How it yields information about the areas being monitored: This activity assists the State to monitor the required 24-hour emergency service availability.

s. x_____ Utilization review (e.g. ER, non-authorized specialist requests)
Applicable program: PMHP Waiver
Personnel responsible: EQRO
Detailed description of activity: During HSAG's contract compliance reviews conducted in accordance with 42 CR 438.358(b)(3), during onsite reviews, HSAG sampled service authorization denials to ensure denials were processed properly.
Frequency of use: During contract compliance reviews and waiver periods
How it yields information about the areas being monitored: This activity gives the State information about the contractors' compliance with BBA regulations on access and adherence to service authorization requirements.

t. _____ Other: (please describe)

Section C: Monitoring Results

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

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

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

x___ This is a renewal request.

- x___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ___ The State has used this format previously, 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:

Monitoring activity: Accreditation for Non-duplication
Confirmation it was conducted as described:

___ Yes
x__ No. Please explain: Not applicable for PMHP contractors

Monitoring activity: Accreditation for Participation
Confirmation it was conducted as described:

___ Yes
x__ No. Please explain: Not applicable for PMHP contractors

Monitoring activity: Consumer Self-Report Data
Evaluation of Access and Evaluation of Quality
Confirmation it was conducted as described:

x__ Yes
___ No. Please explain:

Activity #1:
Summary of results: CY 04 and CY05 MHSIP surveys
The MHSIP survey instrument includes the following domains, and the results are for all PMHP contractors:
General Satisfaction Domain: In this domain, between 79 and 86 percent of respondents reported agreement/strong agreement with three survey items on general satisfaction with services and whether they would recommend their provider to a friend or family member.
Access to Services Domain: In this domain, between 71 and 83 percent reported agreement/strong agreement with survey items on whether services were accessible, the location was convenient, whether staff were willing to see them as often as they felt necessary, whether services were at convenient times, whether they were able to get all the services they thought they needed and whether they were able to see their provider when they wanted to. The lowest percentage of respondents reporting agreement/strong agreement, 71 percent, was for the survey item on staff returning calls in 24 hours; however, roughly 20 percent reported "neutral" or "non-applicable."
Quality and Appropriateness of Services Domain: In this domain, for the majority of survey items, the percentage of respondents reporting agreement/strong agreement ranged between 72-85 percent. Survey items

included whether staff believed that they could grow, change and recover, whether they felt comfortable asking questions about their treatment and/or medications, whether they felt free to complain, whether they were given information about their rights, whether staff encouraged them to take responsibility for their lives, whether staff respected their wishes about who is and is not to be given information about their treatment, and whether staff helped them obtain information they needed to manage their lives. For three other items, percentage of respondents reporting agreement/strong agreement ranged between 66-70 percent. These survey items addressed understanding of side effects to watch for, whether they, not staff, decided their treatment goals, and whether they were encouraged to use consumer-run programs. Again, large percentages reported a neutral or not applicable response.

Perceived Outcomes Domain: In this domain, percentages of respondents reporting agreement/strong agreement with survey items on dealing more effectively with daily problems, being better able to control their lives, being better able to deal with crises, getting along better with family and doing better in social situations, ranged from 57 -75 percent. For the survey items on doing better in school and/or work, improvement in housing situation, and symptoms not bothering them as much, the percentage of respondents reporting agreement/strong agreement ranged from 42- 60 percent. As with other survey items in this domain, large percentages reported a neutral or not applicable response. Lower percentages of respondents reporting agreement/strong agreement in this domain may be due to the fact they are still in treatment and outcomes such as these have not yet been fully realized.

CY05 YSS and YSS-F surveys– CY05 was the first annual state-wide administration for these instruments.

The YSS is divided into the following domains: Access to Services, Satisfaction with Services, Participation in Treatment, Cultural Sensitivity, and Positive Outcomes of Services. Youth ages 12 and older complete the YSS survey.

Access to Services Domain: In this domain, survey items addressed whether the location of services was convenient and whether services were available at convenient times.

Satisfaction with Services Domain: In this domain, survey items addressed overall satisfaction with services, feeling they had someone to talk to who stuck with them, that their provider listened, that they got the right services and as much help as needed.

In the Participation in Treatment domain, survey items addressed their involvement in choosing their services, choosing treatment goals, whether they were actively involved in their treatment, and whether they decided their treatment goals.

Cultural Sensitivity Domain: In this domain, survey items addressed being treated with respect, understanding of their family's cultural traditions, respect for their family's religious/spiritual beliefs, speaking in a way that the client felt understood, and sensitivity to cultural/ethnic background.
Positive Outcome of Services Domain: In this domain, survey items addressed whether they are better at handling daily life, whether they get along better with family, friends and other people, whether they are doing better in school and/or work, whether they are better able to cope when things go wrong and whether they are satisfied with their family life right now.
For all domains, the percentage of youth respondents reporting agreement/strong agreement ranged between 55-73 percent for most items. There were also large percentages (20-30 percent range) of respondents reporting that they were "undecided." The lowest percentages of respondents reporting agreement/strong agreement were for the survey items about helping to choose their services (38 percent) and on whether they, not staff, decided their treatment goals (46 percent). For both of these items, another 28 percent and 31 percent of respondents respectively reported that they were undecided. Because youth are less likely to have sought out treatment themselves, and treatment for youth is generally structured, these responses are to be expected.

It is noteworthy that 73 percent of youth respondents reported agreement/strong agreement that staff treated them with respect and spoke to them in a way they could understand, and that 68 percent reported agreement/strong agreement that the providers listened to what they had to say. These affirmative response rates show that youth, who are often ambivalent about getting treatment, felt a positive connection and rapport with their treatment providers.

The YSS-F is divided into the same domains. In the Access to Service Domain, the percentage of parents reporting agreement/strong agreement that services were conveniently located and offered at convenient times ranged from 77-83 percent.
In the Satisfaction with Services Domain, 88 percent of respondents reported agreement/strong agreement that they were satisfied overall with the services their child received, 89 percent reported affirmatively that the providers listened to what their child had to say, and 90 percent responded affirmatively that if their child needed services in the future, they would use these services again. These are excellent satisfaction ratings.
For other survey items in this domain, the percentage of parents reporting agreement/strong agreement ranged from 62 percent to 83 percent.

In the Participation in Treatment Domain, the percentage of parents reporting agreement/strong agreement with individual survey items ranged from 75-88

percent. Family participation in their child's/family's treatment planning is one of the hallmarks of good mental health care for children/families. Therefore, these percentages are especially significant.

In the Cultural Sensitivity Domain, the percentage of parents reporting agreement/strong agreement with individual survey items ranged from 79-96 percent. Again, these are excellent percentages that demonstrate contractors are mindful of culture in their services.

In the Positive Outcomes of Services Domain, the percentage of parents reporting agreement/strong agreement with individual survey items ranged from 60-62 percent on items about whether their child is better at handling daily life, whether their child gets along better with family members, and with friends and other people, and whether their child is doing better in school and/or work. The percentage of parents reporting they were undecided on these items was about 25 percent. The percentage of parents reporting agreement/strong agreement with survey items about whether their child is better able to cope when things go wrong, whether they are satisfied with their family life right now and whether their child is better able to do things he or she wants to do ranged from 51-55 percent. Again, the lower percentages of parents reporting agreement/strong agreement with items in this domain may be due to the fact their children have not completed treatment and potential outcomes have not yet been fully achieved.
Problems identified: None. For all surveys, for the most part, affirmative response rates for survey items are above 60 percent and in many instances, well above 60 percent, which demonstrates good contractor performance.
Corrective action (plan/provider level): None
Program Changes (system-level): None anticipated at this time. The DSAMH will continue the survey protocol outlined in Section B., Monitoring Plan, "Consumer Self-Report Data," Activity #1, for CY06.

Activity #2:
Summary of results: Bureau of Managed Health Care staff take calls directly from Medicaid enrollees, providers, etc. This mechanism gives State staff the opportunity to monitor issues related to access, quality of care, etc. State staff work with the enrollee, and the PMHP contractor as needed, to answer questions and resolve issues. During the two-year waiver period Bureau staff documented 27 issues from callers.
Problems identified: Example of an access complaint– A health program representative informed bureau PMHP staff that complaints had been received about a contractor that refused to schedule appointments for enrollees who had moved to the contractor's catchment area after their Medicaid card had already

printed for the month with a different PMHP contractor specified. Bureau staff worked with the contractor to clarify policy, ensure they understood contract provisions, etc. It appeared it was a misunderstanding at the reception level at the outpatient clinic. The contractor took the steps necessary to educate intake staff on correct policy. The contractor reported back to Bureau staff on its progress with resolving this misunderstanding among its intake staff and in implementing protocols for staff to follow. Example of a quality of care complaint– A pediatrician contacted the Bureau about a youth whose parent was dissatisfied with a contractor's psychiatrist and was requesting that the pediatrician provide psychotropic medication management. Bureau staff collaborated with the pediatrician and the contractor to determine the best way to provide medication management as the pediatrician was not comfortable managing these medications. The contractor gave the youth a different prescriber to work with. It is interesting to note that while investigating the parent's concerns with the pediatrician and the contractor, it surfaced that there was also question of the parent possibly having Munchausen Syndrome, which could have motivated her complaint. This youth also turned 18 during the course of discussions to resolve concerns. Because of the family issues that became more apparent, the mental health center was even more sensitive to the need to work closely with this youth to transition her to adult services and to help her gain greater independence. This case demonstrates that complaints are often more complex than they initially appear.

Corrective Action (plan level): None identified. Contractors and Bureau staff work collaboratively to determine the best course of corrective action for each complaint. Contractors often just need the opportunity to discuss contract provisions, policies, etc., in order to resolve misunderstandings. Often contractors are not aware there is a problem until staff bring it to their attention. We have found contractors are generally appreciative of the information and the chance to resolve the issue.

Program change (system-wide level): Bureau PMHP staff will be trained on using the Medicaid agency's new Medicaid Managed Care System (MMCS) Incident System for documenting complaints. This system has been in operation for approximately one year. The Incident System allows the staff taking the complaint to enter it into the system and to document progress as the resolution unfolds. Staff can then easily monitor and track the resolution with the enrollee and PMHP contractor. The Incident System tracks complaints by type. Therefore, this system will give Bureau staff information on issues and trends in areas of access, quality, capacity, coverage, authorization, etc. The Bureau's PMHP staff has previously used a separate, internal tracking system but will transition to the MMCS Incident System as soon as training is completed.

Monitoring activity: Data Analysis (non-claims)

Evaluation of Program Impact, Grievances and Appeals
Confirmation it was conducted as described:

x___ Yes
___ No. Please explain:

Activity #1:
Summary of results: During HSAG's onsite reviews, review teams conducted data analyses by sampling grievances and appeals to determine if they were documented in accordance with PMHP contract requirements and resolved by appropriate staff and within required time frames. The findings are contained under Standard VII, Grievance System, Grievance Record Review Summary, in the individual contractors' compliance monitoring reports. (HSAG's contract compliance reports for each PMHP contractor are contained in the CD that accompanies this waiver renewal request.)

Please note that aggregated data for all contractors for this monitoring activity, as well as for all other monitoring activities HSAG conducted, will also be contained in HSAG's annual report, entitled: *Report of External Quality Review Results.* Because HSAG just recently completed its monitoring and is preparing final contractor reports, there has not been sufficient time for HSAG to prepare the annual report required under 42 CRF 438.364(a) for inclusion with this waiver renewal. In consultation with the Regional Office and discussion with HSAG, it was agreed that the State will submit HSAG's annual report to CMS by October 31, 2005.

Problems identified:
Grievances– Problems with grievances centered around contractors not always having complete documentation of grievances in accordance with the PMHP contract, Article X, Grievance Systems. Also, HSAG determined that some of the contractors' written grievance policy and procedures did not specify the documentation requirements for grievances.

Appeals–
In HSAG's review of Valley's appeals (the only contractor with appeals), the review team found Valley to be 100 percent compliant with requirements for documenting and processing appeals. (See Standard VII, Grievance System, Appeals Record Review Summary, in Valley's compliance monitoring report.) This contractor gave appeal resolution decisions within the contractually-required time frames for standard and expedited appeals.

Corrective action (plan/provider level): Contractors will be required to specify in their written grievance system policies and procedures all of the elements that must be documented for grievances and appeals and all procedures related to processing grievances and appeals.

For this finding, and all findings contained in HSAG's compliance monitoring reports, the contractors will be required to submit a corrective action plan to the State within 30 days of receipt of the HSAG contract compliance report. The State and HSAG will review the corrective action plans for completeness. The contractors will be required to include a time line for their corrective action interventions and to submit monthly progress reports to the State until corrective actions are completed. HSAG will conduct follow-up reviews in 2006 on areas that required corrective action. Their findings will be reported in their 2006 annual report.
Program change (system-wide level): In consultation with HSAG, the State has amended the PMHP contract to clarify all of the elements that must be documented for grievances and to clarify that the contractors' grievance system written policy and procedures must also include these documentation requirements.

Activity#2:
Summary of results: The State tracks grievances and appeals through the contractors' semi-annual grievance and appeal reports.

Grievances–
The table below summarizes for each PMHP contractor the number of grievances received from or on behalf of Medicaid adult and child clients between 1/1/2004 and 6/30/2005.

	Adults	Children	Total
PMHP	Grievances	Grievances	All
Bear River Mental	2	1	3

Central Utah	20	1	21
Davis Behavioral	37	21	58
Four Corners	15	1	16
Northeastern	11	2	13
Southwest Center	8	6	14
Valley Mental Health	96	58	154
Wasatch Mental	51	20	71
Weber Human	58	5	63
TOTALS	298	115	413

For the reporting time period of 1/1/04-6/30/04, there were 81 Medicaid adult and 41 Medicaid children's grievances. For the reporting time period of 7/1/04-12/31/04, there were 93 Medicaid adult and 25 Medicaid children's grievances, and for the time period of 1/1/05-6/30/05, there were 124 Medicaid adult and 49 Medicaid children's grievances.

The number of Medicaid children served for these three time periods was approximately 56 to 69 percent of the number of adults served which is reflective in the lower number of children's grievances. The number of children's grievances may also reflect parents' satisfaction with their children's services as noted under the Consumer Self-Report Data monitoring activity and under Quality of Care, Clinical Quality of Care Reviews monitoring activity. Valley also has approximately 50 percent of the Medicaid population; their higher numbers are reflective of this.

Of the 413 total grievances, 106 were access-related, 224 were quality-related and 83 fell into an "other" category. Of the 413 grievances, 396 were resolved within the required time frame. Two grievances were still in the process of being resolved at the time of the report, two were resolved after the time frame, four were not resolved due to clients moving and the center being unable to locate clients to address their concerns, five were not resolved due to clients discontinuing treatment prior to resolution, and four grievances were withdrawn during the resolution process.

Appeals–

For the three six-month reporting periods, only one contractor, Valley Mental Health, reported appeals, eight standard and one expedited appeal. One hospital provider requested a State fair hearing in response to the appeal decision to uphold a claim denial. However, the provider defaulted and the State fair hearing request was subsequently dismissed.

Problems identified: For grievances, contractors reported to the State during its onsite reviews that because clients generally lodge grievances verbally, staff may not be consistent in documenting them, particularly if they are easily and quickly resolved.

Corrective action (plan/provider level): The State discussed with contractors the need to ensure periodic staff trainings/reminders on documenting Medicaid clients' grievances occur. Contractors reported two major forums where these trainings can and do occur: general staff meetings and team-level staff meetings.
Program change (system-wide level): None identified at this time.

Monitoring activity: Enrollee Hotlines and Ombudsman
Evaluation of Program Impact, Evaluation of Access, and Evaluation of Quality
Confirmation it was conducted as described:

__x_ Yes
___ No. Please explain:

Summary of results: Questions received by Customer Service Unit Staff and the Ombudsman often demonstrate that enrollees or providers do not fully understand requirements and limitations of the PMHP, such as "How can I get XYZ mental health center off my Medicaid card?" or "What do I do if I also have Medicare?" or "How can I be a Medicaid provider and bill Medicaid directly (fee-for-service)?" Policy-related questions and complaints give State staff the opportunity to provide individualized, more in-depth information on the PMHP, and to help enrollees get their concerns addressed. Customer Service Unit staff and the Ombudsman resolve questions and issues to the degree possible and then refer callers to Bureau staff for resolution. State staff have found contractors to be willing to resolve issues.
Problems identified: The Ombudsman has been tracking PMHP-related calls in the MMCS Incident System since October 2004. Since October 2004, she has documented seven PMHP-related calls in this new system. She received calls on policy-related questions, concerns about having the name of the mental health center on the Medicaid card, billing questions and concerns with a specific contractor.
Corrective action (plan/provider level): None identified at this time. Issues were resolved for the callers. Again, contractors are willing to work with the State to resolve concerns when they are brought to their attention.
Program change (system-wide level): The Customer Service Unit and the Ombudsman coordinate with Bureau PMHP staff to ensure problems are resolved. As stated under "Consumer Self-Report Data," Activity #2, Bureau of Managed Health Care's PMHP staff will be trained on using the MMCS Incident System so that all complaints are maintained in one internal system.

Monitoring activity: Focused Studies
Confirmation it was conducted as described:

___ Yes
__x_ No. Please explain: See Section B, Focused Studies, for explanation.

Monitoring activity: Geomapping
Evaluation of Access
Confirmation it was conducted as described:

x___ Yes
___ No, Please explain:

Summary of results:

Contractors either operate a major clinic(s) in a county, or in less populated counties, a satellite clinic where core services (i.e., mental health evaluation, individual and family, and possibly group therapy) are offered, or in the frontier counties, deploy clinicians a certain number of days per week/month to provide services. For more specialized services, (e.g., physician medication management, day treatment, etc.) clients in frontier counties may need to obtain them from the closest clinic site if there is not enough service volume to justify the service (and the clinician travel time involved) in that county.

Problems identified: The vastness of the rural contractors' catchment areas and the frontier status of some of their counties pose unique challenges for service delivery systems. However, no specific access/capacity problems were found with any one contractor. All contractors have basic services (mental health evaluation and individual, family and group therapy) available in all counties. Because of the costs associated with physician services and the need to provide as much direct care as possible due to demand and limited psychiatrist resources, their long distance travel is understandably kept to a minimum. Consequently, clients living in outlying/frontier areas may have to travel to the closest clinic site to receive these services. Contractors routinely provide daily transportation to day treatment programs for clients living in outlying/frontier areas. The contractors also arrange for transportation to and from mental health services as needed. Providers assess clients' transportation needs on a case-by-case basis. Also see the onsite review monitoring activity, Evaluation of Access: Service/Specialist Capacity.

Corrective action (plan/provider level): Contractually, contractors are required to assess on an ongoing basis their service delivery arrangements.

Program change (system-wide level): None at this time.

Monitoring activity: Independent Assessment

Confirmation it was conducted as described:

___ Yes
_x__ No. Please explain: Not required for this waiver.

Monitoring activity: Measure any disparities by racial or ethnic groups

Evaluation of Quality

Confirmation it was conducted as described:

_x__ Yes
___ No. Please explain:

Summary of results: In the MHSIP survey, for the survey item, "Staff were sensitive to my cultural background (race, religion, language, etc.)," for all contractors the percentage of respondents agreeing/strongly agreeing with this statement was 73 percent, with only 4.5 percent disagreeing. The remainder of respondents reported neutral or not applicable responses.

In the YSS and YSS-F, there are three survey items addressing cultural sensitivity: Staff understanding of the family's cultural traditions, staff's respect for the family's religious/spiritual beliefs and staff sensitivity to cultural/ethnic background. On the YSS, 58 percent, 66 percent and 59 percent of youth respondents reported agreement/strong agreement with these statements respectively. Between 29 and 32 percent reported they were undecided and the remainder reported disagreement or strong disagreement. On the YSS-F, for the same survey items, 80 percent, 85 percent and 79 percent of parent respondents reported agreement/strong agreement with these statements respectively. This difference in response rates between the youth and parents show that youth may be more inclined to view treatment more negatively. The adult affirmative response rates to the MHSIP survey item, and the parent's affirmative response rates to the YSS-F survey items are excellent and demonstrate the contractors are attempting to provide culturally sensitive services.
Problems identified: None
Corrective action (plan/provider level): PMHP contractors are required to implement cultural competency plans that include a provider training and education component. Training and education are mechanisms to assist staff to provide culturally sensitive services. Also see the onsite review monitoring activity, "Evaluation of Quality," "Quality of Care, Cultural Competency," for more information on contractors' training and education initiatives.
Program change (system-wide level): None identified at this time.

Monitoring activity: Network adequacy assurance by plan
Confirmation it was conducted as described:

___ Yes

_X__ No. Please explain: See Section B for explanation.

Monitoring activity: Onsite review:
Evaluation of Program Impact, Evaluation of Access and Evaluation of Quality
Confirmation it was conducted as described:

x___ Yes

No. Please explain:

Evaluation of Program Impact

· Information to Beneficiaries

Summary of results: In HSAG's compliance monitoring reports, see Standard VIII,
Enrollee Information, and Standard IX, Enrollee Rights, for findings and opportunities for
improvement. Also see HSAG's annual *Report of External Quality Review Results*, which
will contain aggregated data on information to beneficiaries.

Problems identified: HSAG found that the contractors' Medicaid handbooks needed
additional information or modification in one or more of the following content areas:
availability of assistance in filing a grievance or appeal, reference to a toll-free number
for filing an appeal or a grievance, the fact that, when requested by the enrollee, benefits
(services) may continue if the enrollee files an appeal or a State fair hearing request
within the required time frames when the action was to reduce, suspend or terminate a
previously approved course of treatment, and a statement that upon request, enrollees can
get information on the structure and operation of the PMHP. HSAG also found that some
of the contractors' patient rights statements that existed prior to the managed care
regulations had not been changed to also include the BBA-specified enrollee rights
(although these rights are included in their Medicaid handbooks).
Corrective action (plan/provider level): The contractors will make needed changes to
their Medicaid handbooks and will modify any separate patient rights statements to
include the BBA enrollee rights for PMHP clients.
Program Change (system-wide level): In consultation with HSAG, the State has amended
the PMHP contract to clarify that the enrollee rights specified in 42 CFR 438.100 (b)(2)
must be included in both their Medicaid Member Handbook and in any other separate
patient rights documents that pre-date the managed care regulations. The State will also
update its boilerplate Medicaid Member Handbook to add the same information HSAG is
requiring contractors to add or modify in their individual Medicaid handbooks.
Contractors can then use the boilerplate as a reference document as needed.

Evaluation of Access

· Timely Access

Summary of results: The PMHP contractors have performance standards for providing
timely access to first mental health service (i.e., evaluation).
Standards have been established for enrollees needing emergent, urgent and non-urgent
care.

Emergent care need: Enrollees determined to have an emergent need are to be clinically screened within 30 minutes of a call for crisis services. The contractor is then required to offer a face-to-face emergency appointment within one hour or other mutually agreed upon time frame.

Urgent care need: Enrollees determined to have an urgent need are to be offered an appointment for mental health evaluation within five working days. At the time the appointment is made, contractors are also required to inform the enrollee about accessing emergency services in the interim should this service become necessary.

Non-urgent care need: Enrollees determined to have a non-urgent need are to be offered an appointment for a mental health evaluation within fifteen working days.

The contractors submit annual reports to the State summarizing adherence to performance standards for emergent, urgent and non-urgent care.

The contractors submitted their first annual report to the State summarizing performance for CY2004. While onsite, using the ISCAT tool, HSAG reviewed the contractors' management information systems and their ability to accurately document and report their performance to the State.

During this onsite review, HSAG validated the contractors' reported performance using CMS' protocol for validating performance measures. (HSAG's performance measures validation reports for each PMHP contractor are contained in the CD that accompanies this waiver renewal request. Also see HSAG's annual *Report of External Quality Review Results,* that will contain aggregated information on performance standards.)

Six contractors were fully compliant and two were substantially compliant in that they followed the requirements for documenting initial contacts and were able to demonstrate how they gathered the data. One contractor's processes were determined to be invalid.

HSAG determined the degree to which the contractors' reported data were biased using plus or minus five percent as the benchmark.

Problems identified: Contractors had varied problems with documenting the data elements required in order to calculate their performance. Also, although they could explain how they calculate their performance, some did not have written procedures. HSAG found that usually one staff person was designated to do the calculations. In their absence, there were no written protocols other staff could follow.

Corrective action (plan/provider level): Contractors will be required to correct identified deficiencies so that they are documenting and/or capturing all required performance data elements, calculating performance correctly, etc. The State and HSAG will also conduct follow-up telephone technical assistance conferences with the plans to discuss their CY04 reports, problems they had with reporting, limitations they observed with the annual report template, etc. During HSAG's 2006 performance measure validation activities, the review teams will determine if contractors have made changes identified as necessary in their 2005 validation reports. Contractors will also be required to document their procedures for calculating performance.

Program Change (system-wide level): Based on review of contractors' reported performance and in consultation with HSAG and the contractors, the State will modify the performance measures reporting template to address problems/limitations with the existing template. This was our first year using this template. It was anticipated it would need refinement after the contractors used it for the first reporting period. The State also amended the PMHP contract to require contractors to have written policies and procedures for calculating their performance.

· Service/Specialist Capacity

Summary of results: During HSAG's onsite reviews, the review teams assessed contractors' capacity and access. See HSAG's compliance monitoring reports, Standard I, Capacity and Access, Performance Strengths and Performance Improvement Opportunities, and HSAG's annual *Report of External Quality Review Results*, which will contain aggregated information for this monitoring area.

Problems identified: HSAG found no specific access/capacity problems with any one contractor. All contractors received a "Met" score in this area.

Corrective action (plan/provider level): Contractually, the contractors are required to assess on an ongoing basis their service delivery arrangements.

Program change (system-wide level): None at this time.

· Coordination/continuity

Summary of results: In HSAG's compliance monitoring reports, see Standard IV, Coordination and Confidentiality, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results*, which will contain aggregated information on both coordination and confidentiality.

Problems identified: Eight of the nine contractors received a "Met" score and one contractor received a "Substantially Met" score. This contractor lacked written policies and procedures to ensure that confidentiality of protected health information is

maintained. Also, the contractor was not able to produce documentation of staff who had
attended training on HIPAA privacy requirements.
Corrective action (plan/provider level): The contractor will put its policies and procedures
in writing and document staff trainings.
Program Change (system-wide level): None identified at this time.
Also see Performance Improvement Projects monitoring activity below. The PMHP
contractors are conducting a clinical PIP to improve coordination of care with other health
care providers.

Evaluation of Quality

Coverage/Authorization
Summary of results: In HSAG's compliance monitoring reports, see Standard II, Service
Authorization, and Standard III, Service Coverage, for findings and opportunities for
improvement. Also see HSAG's annual *Report of External Quality Review Results,* which
will contain aggregated information on service coverage and service authorization.
Problems identified: All contractors received a "Met" score for Standard III, Service Coverage."
For Standard II, Service Authorization, six contractors received a "Not Score" finding because they did not have written policies and procedures addressing requirements for processing initial and continuing service authorization requests and they had not had actions that required notice of action to the enrollee. If they had actions, and in the absence of written policies and procedures were able to explain the policies and procedures that were followed, they were given a score in this area.
Corrective action (plan/provider level): Contractors will be required to put their service authorization policies and procedures in writing if they have not done so. One contractor had draft written policy and procedures and all others had flow charts showing the service authorization/denial/notice of action processes and time frames that they follow, but they did not have formal written policies and procedures to accompany the flow charts.
Program Change (system-wide level): In consultation with HSAG, the State has also amended the PMHP contract to clarify that service authorization policies and procedures, and time lines for authorizations, etc., as specified in Article IX, Authorization of Services and Notices of Action, of the PMHP contract must be in writing and that flow charts diagraming the policies and procedures alone are insufficient.

• Provider Selection

Summary of results: In HSAG's compliance monitoring reports, see Standard VI, Provider Selection, Retention, Credentialing, Recredentialing, Subcontractor Relationships and Delegation, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results*, which will contain aggregated information on monitoring in this area.

Problems identified: Two contractors received a "Substantially Met" score, two contractors received a "Partially Met" score and five contractors received a "Not Met" score. Problems centered around contractors not having written policies and procedures for one or more of the following: policies directing selection and retention of providers, policies addressing non-discrimination against providers who serve high-risk populations, procedures for notifying providers of the reason for denying their request to participate on the contractor's panel, policies and procedures on credentialing and recredentialing of providers, and procedures for notifying licensing boards when suspensions or terminations of providers occur because of quality of care issues. Deficiencies in contractors's written subcontracts were also identified. These deficiencies ranged from not including the statement that subcontractors will not be prohibited from advising or advocating on behalf of an enrollee on treatment options, not including a requirement that the subcontractor participate in the contractor's quality assurance (QAPI) program, not including a copy of or incorporating by reference the DSAMH's preferred practice guidelines, not including information about the contractor's grievance system, and not including a provision that if the subcontractor becomes insolvent enrollees cannot be billed.

Corrective action (plan/provider level): Contractors will be required to develop written policies and procedures where deficient, and to amend their subcontracts as needed.

Program Change (system-wide level): In consultation with HSAG, the State has amended

the PMHP contract to clarify that delivery network policies and procedures must be in
writing and to clarify all of the components that must be included in written subcontracts.

- Quality of Care

Cultural Competency

Activity #1:

Summary of results: See HSAG's compliance monitoring reports, Standard V, Cultural
Competency, for findings and opportunities for improvement regarding the contractors'
cultural competency plans. Also see HSAG's annual *Report of External Quality Review
Results*, which will contain aggregated information on monitoring in this area.
Problems identified: Some of the contractors' cultural competency plans were not written,
and others did not include all required components.
Corrective action (plan/provider level): Contractors will be required to put their cultural
competency plans in writing and include all required components as specified in the
PMHP contract.
Program change (system-wide level): In consultation with HSAG, the State has amended
the PMHP contract to clarify that cultural competency plans must be written.

Activity #2:

Summary of results: During the State's onsite reviews, the State focused on the
contractors' cultural competency educational initiatives that were underway during the
preceding fiscal year (FY05) that they had reported on to the State. Contractors had a
variety of initiatives and all were designed to enhance clinical services. Initiatives
included:

special focus and emphasis on recruitment of culturally and linguistically diverse staff (by advertising in special community newspapers and newsletters and advertising outside the state;
offering signing bonuses to clinicians from other cultures or with other language fluency);
providing segments on cultural competency in new employee trainings and staff meetings, contractor newsletters and computer bulletin boards with information

on cultural competency (some centers followed-up with quizzes after the newsletters);
computerized and video self-administered trainings;
onsite reference libraries and materials for staff;
formal presentations on various cultures in staff meetings, this past year, particularly on Native American, Latino and Asian/Pacific Islanders, by members of these groups;
development of specific clinical teams that are culturally and linguistically diverse to meet the needs of the refugee population;
clinical trainings to increase therapists' ability to take overall culture and equally as important, the client's/family's own unique culture into account in treatment planning and service delivery.

Contractors will continue these initiatives during FY2006. A major focus for this year will be on integrating and documenting culturally relevant information into the client clinical assessment and treatment planning process. Contractors will also review the MHSIP and YSS and YSS-F feedback on the cultural competency survey items. One contractor has a staff person review the clinical charts for clients who reported less favorably on these survey items to determine if there is anything in the clinical documentation that may support why the clients responded as they did. This is an excellent quality improvement activity.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

Also see the Provider Self-Report Data monitoring activity, "Evaluation of Quality: Cultural Competency."

<u>Grievance Systems</u>

Summary of results: HSAG reviewed the contractors' grievance systems for compliance with managed care regulations at 42 CFR 438.400-438.424, Subpart F. In HSAG's compliance monitoring reports, see Standard VII, Grievance System, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results*, which will contain aggregated information on monitoring in this area.

Problems identified: HSAG found that five of the nine contractors had not put their

grievance systems in writing. Contractors had flow charts diagraming the grievance system policies, procedures and time frames for processing grievances, appeals and giving State fair hearing information, but they did not have accompanying written documents.

Two contractors did have written documentation of their grievance system policy and procedures and two had draft documents.

Corrective action (plan/provider level): If not already documented, contractors will put their grievance system policies and procedures in writing.

Program change (system-wide level): In consultation with HSAG, the State has amended the PMHP contract to clarify that all aspects of the grievance system policy and procedures, time lines, etc., must be in writing and that flow charts diagraming the policies and procedures alone are insufficient.

Quality Assessment and Performance Improvement (QAPI)

Summary of results: HSAG reviewed the contractors' QAPI programs for compliance with managed care regulations at 42 CFR 438.240. In HSAG's compliance monitoring reports, see Standard X, Quality Assessment and Performance Improvement, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results,* which will contain aggregated information on monitoring in this area.

Problems identified: Contractors had varying deficiencies in terms of their written QAPI plans containing all required components. One contractor's plan was excellent while others needed to be revised to include additional information.

Corrective action (plan/provider level): Contractors are required to update their written QAPI program plans to include all required components.

Program change (system-wide level): In consultation with HSAG, the State has amended the PMHP contract to clarify that contractors must have a written QAPI program plan and to more clearly specify all of the components that must be included in their written QAPI plans.

Practice Guidelines

Summary of results: In HSAG's compliance monitoring reports, see Standard XI, Practice Guidelines, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results,* which will contain aggregated information on monitoring in this area.

Problems identified: Some contractors did not have a mechanism for disseminating preferred practice guidelines to subcontractors. Also, some contractors that had developed guidelines in addition to those published by the DSAMH did not have written policies and procedures for their adoption, implementation and periodic review and update.

Corrective action (plan/provider level): Contractors will be required to include a copy of the preferred practice guidelines with their subcontracts (or incorporate the guidelines by reference) and to have written policies and procedures for developing/adopting and implementing guidelines in addition to the DSAMH's guidelines.

Program change (system-wide level): In consultation with HSAG, the State has amended the PMHP contract to clarify that their written QAPI program plans must address development, adoption and implementation of preferred practice guidelines if they develop guidelines in addition to those developed by the DSAMH. The State has also amended the PMHP contract to clarify that contractors' written subcontracts must include preferred practice guidelines as an attachment or through incorporation by reference to a website with the guidelines.

Clinical Quality of Care Reviews

The DSAMH is the state mental health authority in Utah. Each state fiscal year, the DSAMH conducts clinical reviews on selected DSAMH-developed preferred practice guidelines. Adult and child client samples are randomly selected for each mental health center. Approximately 75 percent of the clients sampled for the FY2004 reviews were

Medicaid clients and approximately 80 percent of the clients sampled for the FY2005
reviews were Medicaid clients.
The DSAMH's review protocol includes interviews with center administrative teams,
clinical record reviews for the sampled clients and clinical "staffings" with the therapists
providing services. Staff from partner agencies involved in the clients' care, and parents
of sampled children, are also invited to participate in these staffings. In addition, for the
children's treatment reviews, the family advocate member of the DSAMH review team
interviews the sampled children's parents to determine their satisfaction with treatment.
Adult reviews:
Summary of results: The SFY2004 and SFY2005 reviews focused primarily on the
preferred practice guideline for conducting annual assessments of involuntary physical
movements for all clients who have been receiving neuroleptic medications for longer
than six months. The guideline calls for using an assessment tool such as the Abnormal
Involuntary Movement Scale (AIMS). For both review periods, the review team found
that about half of the contractors needed to make some degree of improvement to ensure
these annual assessments are performed timely for this group of clients. Reviews also
focused on coordination with health care providers for clients receiving medications.
Problems identified: The review team determined that centers need to develop formal
protocols for evaluating this client population so that evaluations are completed routinely
and timely. It was also determined that coordination with physical health care providers
for clients on psychotropic medications could be improved.
Corrective action (plan/provider level): The DSAMH has recommended that the centers
develop protocols to ensure consistent use of the AIMS (or other similar
assessment tool), and that they designate a location in the medical record where the
assessment documentation will be kept. The DSAMH supports the coordination of care

PIPs as the method for improving coordination with physical health care providers.
Program change (system-wide level): None.

Children's reviews:
Summary of results–SFY2004 reviews: These reviews focused on preferred practice guidelines for clinical assessment and treatment planning, collaboration with other agencies serving the children, and guidelines on the development of crisis or safety plans for children who may be at risk for harming self, others or property. Crisis or safety plans are designed for families and others to follow in times of crisis or escalation of risky behaviors at home, school, or in other community settings.

The review team found that: clinical assessments were comprehensive, parents/caregivers were the primary source of information for assessment and treatment planning, treatment plans were individualized and included well-developed treatment goals, treatment methods were appropriate to meet the child's treatment goals, family members were involved in their children's care, services provided were appropriate and "flexible" (e.g., appointment times and locations were convenient, centers provided transportation when needed, frequency of appointments was individualized, etc.), the treatment settings were "family-friendly," (e.g., offices are designed to include whole families in services, waiting rooms are geared to children, services are provided in the home, etc.), and based on the parent interviews, parents/caregivers were highly satisfied with the clinical services their children received.
Problems identified: The review team determined that there was not a consistent approach for assessing the need for and developing crisis or safety plans, and if crisis/safety plans were developed, they were often difficult to locate in the clinical record. This could be problematic for on-call crisis workers needing to access them after-hours. The team also determined that five of the contractors needed to improve documentation of collaboration with other agencies serving the sampled children. During the clinical staffings, the

reviewers found that clinicians were collaborating; however, the activities were not consistently documented in the child's record.
Corrective action (plan/provider level): The DSAMH required the centers to focus their corrective action efforts for the upcoming year on developing processes to ensure crisis/safety plans are developed and documented for children at risk of harm to self, others or property.
Program change (system-wide level): The DSAMH provided technical assistance to the mental health centers on crisis/safety plans, how they differ from the clinical treatment plan, and on the components of a good crisis/safety plan. Each center developed its own crisis/safety plan format and designated the location in the clinical record where the plan would be documented.
Summary of results– FY2005 reviews: The reviews again focused on preferred practice guidelines for clinical assessment and treatment planning and crisis/safety plans. The review team found that the mental health centers had vastly improved in the area of crisis/safety plans. The reviewers found that the crisis/safety plans were detailed and easy to locate in the clinical records, and that they were developed in collaboration with parents and caregivers. The reviewer also determined that the centers had made good progress with documenting collaboration with other agencies, and that they had maintained their good performance in the area of clinical assessments and treatment planning. Based on the parent interviews, parents again reported high satisfaction with their children's treatment.
Problems identified: None.
Corrective action (plan/provider level): The DSAMH emphasized that centers should continue their focus on collaboration and coordination with other providers and provide supervisory support and training of staff on this activity. The DSAMH will provide technical assistance to the centers as needed on improving collaboration as well as in any other areas as necessary.
Program change (system-wide level): To help children's clinicians improve their clinical skills, knowledge, etc., the DSAMH has conducted and plans to continue to

conduct additional regional clinical trainings.
During SFY2005, in collaboration with two PMHP contractors in the northern area of the
state, the DSAMH provided a two-day clinical training on helping children deal with loss
and trauma. The DSAMH encourages all mental health centers to send clinical staff to
these trainings. The DSAMH also plans to provide more regionally-based clinical
trainings for children's staff so that all centers have the opportunity to participate in
trainings that require less travel time.

Monitoring activity: Performance Improvement Projects (PIPs)
Evaluation of Access, Timely Access and Coordination/Continuity
Confirmation it was conducted as described:

_x__Yes

No. Please explain:

Summary of results: In accordance with 42 CFR 438.240(d), PMHP contractors are
conducting a clinical PIP and a non-clinical PIP. The State chose the clinical topic
(improvement in coordination of care with other health care providers). All PMHP
contractors and health plan contractors under the Choice of Health Care Delivery Waiver
are conducting a PIP to improve coordination of care.

The State and the PMHP contractors agreed that the focus of their non-clinical PIPs
would be on improving aspects of their performance measures initiative. Contractors
selected the specific focus of their non-clinical PIP using their CY2004 performance
measures data to help them identify areas needing improvement. For example, contractors
may have determined that they needed to improve their procedures for documenting
required data elements, to ensure staff consistently document the needed data elements,
that they should automate manual processes, etc., or that they need to improve their
capacity to meet the standards if this is problematic. At the time of HSAG's CY 2005
PIP validation activities, contractors were in the process of designing their projects. The

contractors are following CMS' protocol for conducting PIPs and had generally completed
activities #1-6 of CMS' protocol. They reported on these PIP activities in the PIP reports
they submitted to HSAG for validation.
Problems identified: Conducting projects in accordance with a formally defined protocol
is a new activity for the contractors. Understandably, during HSAG's validation activities,
reviewers identified activities that require modification in order to meet the CMS
protocol for conducting PIPs. Developing answerable/provable study questions and well-
defined, objective and measurable study indicators that allow the study question to be
answered, and providing a manual data collection tool, when applicable, were the major
activities where contractors received a "Partially Met" or "Not Met" status. (HSAG's
Performance Improvement Project Validation reports for each PMHP contractor are
contained in the CD that accompanies this waiver renewal request. There are two
validation reports per PMHP contractor: one for the non-clinical PIP and one for the
clinical PIP. Also see HSAG's annual *Report of External Quality Review Results,* which
will contain aggregated information on PIPs.)

HSAG is currently providing technical assistance to each contractor on their two
PIPs. They are focusing their discussion on the activities #1-6 that received a "Partially
Met" or "Not Met" status. HSAG's technical assistance is extremely valuable in helping
contractors better understand CMS's protocol for conducting PIPs and how to conduct
various activities (e.g., design an answerable/provable study question, select a statistically
valid sample, select valid study indicators, etc.).
Corrective action (plan/provider level): Contractors are revising PIP designs (activities #1-
6) as needed based on HSAG's CY 2005 validation activities and technical assistance.
They will resubmit their PIP reports to HSAG within 30 days of the technical assistance,
with revisions as needed to activities #1-6. HSAG will provide feedback to the
contractors about whether the revised PIP documentation is now sufficient. This will

provide the framework as contractors move forward with their PIP activities. In January, 2006, HSAG will provide additional technical assistance to the contractors on PIP protocol activities #7-10 so that they are prepared to move to implementation of these activities. The contractors' revised PIP reports will be included in HSAG's 2006 PIP validation activities. HSAG will not revise the contractors' 2005 PIP validation scores based on the technical assistance and their submission of revised PIP activity documentation.
Program change (system-wide level): None identified at this time.

Monitoring activity: Performance Measures
Evaluation of Access
Confirmation it was conducted as described:
_x__ Yes
No. Please explain:
Summary of results: The State reviews the contractors' annual reports and reviews them with HSAG.
Problems identified: The State found that some of the contractors' reported numbers seemed incorrect, even though HSAG reported they did not bias the validation findings by more than plus or minus five percent.
Corrective action (plan/provider level): The State and HSAG are currently scheduling follow-up technical assistance calls with each contractor to discuss the numbers reported in their CY2004 reports. Where there are errors, contractors will be required to ensure they make needed corrections so that they report accurately for CY2005.
Program change (system-wide level): See " Evaluation of Access," "Timely Access," above. The State, in consultation with HSAG and the contractors, will modify the performance measures report template.

Monitoring activity: Periodic comparison of number of providers
Evaluation of Access
Confirmation it was conducted as described:
x___ Yes
No. Please explain:
Summary of results: The contractors provide clinician FTE data to the State as of a point

in time, July 1 of each year. For this waiver period, the State calculated the number of
filled FTEs per 1000 PMHP enrollees as of July 1, 2003, 2004 and 2005. The ratios
remained consistent over the three years.
The contractors also report annually on the number of prescribers (MDs and APRNs) that
they have as of the same point in time, July 1. All contractors maintained the same level
of prescriber staff, with one rural contractor adding an APRN to their staff, and another
contractor being able to fill a previously vacant physician FTE.
Problems identified: None. Clinician capacity has remained consistent over time.
Corrective action (plan/provider level): None identified at this time.
Program change (system-wide level): None identified at this time.

Monitoring activity: Profile Utilization by Provider Caseload
Evaluation of Access
Confirmation it was conducted as described:
x___ Yes
___ No. Please explain:
Summary of results: The State compared contractor penetration rates for outpatient
services using FY01, FY02, FY03 and FY04 encounter data. Penetration rates were
calculated separately for Medicaid adult and Medicaid child clients. For children,
contractors' penetration rates remained consistent over this four-year period. For adults,
six contractors' penetration rates were consistent across the years and one contractor's rate
increased five percent in FY04 compared to previous years. Two contractors' penetration
rates decreased in FY04 (by seven percent and five percent respectively compared to
previous years).
Problems identified: Since staffing has not changed, the decrease in penetration rates
could represent normal fluctuation, or encounter data may not have been complete.
Corrective action (plan/provider level): System-wide level encounter validation activities
summarized below will lead to plan-level corrective actions.
Program change (system-wide level): The State will continue to monitor penetration rates.
Also, HSAG is beginning its encounter validation activities. These validation activities

will help the contractors with any data completeness problems that could lead to under-
reporting of Medicaid clients.

Monitoring activity: Provider Self-Report Data
Evaluation of Program Impact: Program Integrity, and Evaluation of Access and Evaluation of Quality
Confirmation it was conducted as described:
x___ Yes
No. Please explain:

Evaluation of Program Impact: Program Integrity
Summary of results: In accordance with the PMHP contract, contractors submit information on fraud and abuse investigations. Contractors are required to report annually the number of complaints that warranted preliminary investigations. Contractors are also required to submit reports of any additional full investigations within 30 days after completion of the investigation. Three contractors reported preliminary investigations that were resolved without necessitating further full investigations. One contractor reported a full investigation on timely completion of treatment plans.
Problems identified: This contractor found problems with clinicians completing treatment plan reviews/updating of treatment plans timely (at least every 180 days).
Corrective action (plan/provider level): The contractor implemented a process whereby the computerized record system now generates reports to monitor treatment plan review dates and advance reminders to clinicians at the beginning of each month specifying clients whose treatment plans are due during that month. The electronic clinical record now prohibits entry of a progress note if the treatment plan review has not been completed by the due date. The contractor also conducted staff training on treatment plans, treatment plan reviews, and the computerized system for oversight of this clinical process. Clinical directors will also periodically monitor samples of clients to ensure improvement is maintained.
Program change (system-wide level): None identified at this time.

Evaluation of Quality: Cultural Competency

Summary of results: The contractors submit annual reports to the State summarizing cultural competency initiatives that occurred in the preceding fiscal year and those planned for the upcoming fiscal year. These reports are discussed with the contractors during the State's onsite reviews. See the summary of cultural competency initiatives under the onsite review monitoring activity, "Evaluation of Quality," "Quality of Care: Cultural Competency," Activity #2.

Problems identified: The State determined that the reporting template needs to be revised to more clearly elicit information in all three of the areas of their cultural competency plans. Currently, contractors report primarily on their training initiatives/topics, rather than on staff recruitment and retention and treatment planning and service delivery initiatives.

Corrective action (plan/provider level): With the revised reporting template, contractors will provide more detailed information on cultural competency activities in all three areas of the cultural competency plan.

Program change (system-wide level): The State will revise the 2006 report template.

Monitoring activity: Test 24/7 emergency service availability

Evaluation of Access

Confirmation it was conducted as described:

_x__ Yes

No. Please explain:

Summary of results: Using the information in the contractors' Medicaid handbooks, the State called the contractors' after-hours telephone numbers listed to determine if the numbers were correct and once connected, if the directions on how to proceed in the case of a crisis were clear.

Problems identified: None. All telephone numbers listed in the Medicaid handbooks were correct and either a live person providing crisis coverage answered or a recorded message gave clear directions on how to proceed (e.g., the number to call, etc.).

Corrective action (plan/provider level): None.

Program change (system-wide level): None identified.

Monitoring activity: Utilization Review

Evaluation of Quality, Authorization

Confirmation it was conducted as described:
___ x Yes
No. Please explain:
Summary of results: See HSAG's compliance monitoring reports, Standard II, Service Authorization, Utilization Management Denials, Record Review Summary, for findings and opportunities for improvement. Also see HSAG's annual *Report of External Quality Review Results,* which will contain aggregated information on utilization review results. The majority of contractors had not denied service authorization requests to obtain services from outside providers. For two contractors, there were a total of seven denials. HSAG reviewed these to determine if contractors had followed the service authorization requirements specified in Article IX, Authorization of Services and Notices of Action.
Problems identified: For one of the sampled service authorizations, the contractor needed to take the additional time allowed to make the authorization decision. The notice to the enrollee about this extension was not sent timely. HSAG also found that a contractor's notice of action letters about reducing, suspending or terminating a previously approved course of treatment did not specify the date that the action would take effect.
Corrective action (plan/provider level): Contractors will be required to correct their notice of action letters as needed.
Program change (system-wide level): The State will work with the contractors as a group to ensure notice of action letter templates are corrected/revised as needed.

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: Randy Baker
c. Telephone Number: 801-538-6673
d. E-mail: Randybaker@utah.gov
e. The State is choosing to report waiver expenditures based on

x___ date of payment.

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

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

a._x__ The State provides additional services under 1915(b)(3) authority.
b.___ The State makes enhanced payments to contractors or providers.
c._x__ 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.

D. 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._x__ PIHP
c.___ PAHP
d.___ Other (please explain):

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

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

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

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

the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

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

F. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: NA

a.___ Population in the base year data

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

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

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

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

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

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

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

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

For Conversion or Renewal Waivers:

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

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

c._x__ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: Observed enrollment in R1(CY04) and R2 (CY05) and projected forward.

d. _x_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: No other variance observed.

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

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

For Initial Waivers: NA

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**: Medicaid pharmacy expenditures for dual eligibles, except for barbiturates, over-the-counter drugs and benzodiazepines (BOBs), are excluded from R1 and R2.

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: Same as above.

H. 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: NA

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.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

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

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

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a._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.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections *See Appendix D.3*

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Psychoeducational Services Personal Services Respite Care Supportive Living			
Total	(PMPM in Appendix D3 Column H x member months should correspond)		(PMPM in Appendix D5 Column W x projected member months should correspond)

b.NA 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.NA 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. NA Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

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

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

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

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

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

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

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

a. State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-

specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

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

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

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

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

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

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

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

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

Others:

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

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

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

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

For each change, please report the following:

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

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

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

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

E.____Other (please describe):

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

iii.__ Changes brought about by legal action (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

iv.__ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

v.__ Other (please describe):

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

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

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

D.____Other (please describe):

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

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

2.___ An administrative adjustment was made.

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

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

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

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

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

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

C.____Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

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

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

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

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

3.___ Other (please describe):

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

1.___ GME adjustment was made.

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

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

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

Method:

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

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

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

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

Basis and Method:

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

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

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

Method:

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

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

Basis and method:

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

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

Basis and Method:

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

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

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

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

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

2.___ This adjustment was made:

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

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

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

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

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

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

4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

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

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

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

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the	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).

Adjustment	Capitated Program	PCCM Program
	PCCM With Waiver Calculations -- See the next column)	

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

2._x__ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting 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 R1 and R2 (CY04 and CY05). 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. Linear regression. The State's cost increase does not include any additional factors.

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 R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

_ Additional State Plan Services (+)

_ Reductions in State Plan Services (-)

_ Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)

_ Graduate Medical Education (GME) Changes - This adjustment accounts for changes in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.

_ Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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

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

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

For each change, please report the following:

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

B.____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.__x_**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.

vi.__ 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:

vii.__ 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):

viii.__ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

vi.__ Other (please describe):

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

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

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

D.____Other (please describe):

c. x **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should*

not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

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

2._x__ An administrative adjustment was made.

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

ii._x__ Cost increases were accounted for.

A. _x__Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP). The State has a contract with a vendor to conduct EQR from 1/1/2005-12/31/2007. The total amount applicable to this waiver is $1,232,748 or $411,000 per year in R2, P1 and P2. The State also has a contract with an actuarial firm to conduct rate setting. The total applicable to this waiver is $204,000 in R2, P1 and P2.

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: 3%. Please document how that trend was calculated: Normal inflation for State employees' compensation and benefits.

D.____Other (please describe):

iii. x [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 R1 and R2 (CY04 and CY05) In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Linear regression.

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase. The State's cost increase does not include any additional factors.

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: "State historical cost increases" was checked in D. I. J.a 2.i. above.

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

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2._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. Please document both trend rates and indicate which trend rate was used.

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

1. Please indicate the years on which the rates are based: base years R1 and R2 (CY 04 and CY 05)
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): The inflation factor used by the actuaries for trending state plan services for rate purposes has been applied to the 1915(b)(3) trend in the chart for conversion/renewal waivers contained in D.I. H.

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above: "State historical cost increases" was checked in D. I. J.a 2.i. above.

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

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

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

_ If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

_ Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

_ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

_ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Basis and Method:

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

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

3.___ Other (please describe):

1.__ No adjustment was made.

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

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

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**:

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**:

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

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

Part II: Appendices D.1-7

Appendices D.1-7– Submitted electronically to the Central Office and the Regional Office on October 3, 2005.