Wyoming Section 1915(b) Waiver: Wyoming Medicaid's Youth Initiative –A High fidelity wraparound (HFWA) Community-Based Alternative for Youth with Serious Emotional/Behavioral Challenges

Amendment to be effective
July 1, 2016

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Instructions – see Attachment 1

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

Facesheet

The **State** of Wyoming 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 High fidelity wraparound (targeted case management provided via a HFWA delivery model) (HFWA) for Children with Serious Emotional Disturbance.

Type of request. This is an:
____initial request for new waiver. All sections are filled.
_X__ amendment request for existing waiver, which modifies Section D/Part 1, H.,d.
__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
__ Document is replaced in full, with changes highlighted
___ renewal request
__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
__ 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 amendment is requested for a period of 3 years; effective July 1, 2016 and ending June 30, 2019.

State Contact: The State contact person for this waiver is Lisa Brockman, Children's Mental Health Waiver Manager and can be reached by telephone at (307) 777-7326, or fax at (307)777-6964, or e-mail at Lisa.Brockman@wyo.gov.

Section A: Program Description

Part I: Program Overview

Tribal Consultation

All Federally recognized tribes in the State of Wyoming have been notified of this waiver and have had the opportunity to review and comment on the waiver proposal pursuant to the process approved with the Medicaid State plan. The notification letter is attached to this waiver as Attachment A. Conference calls were scheduled and held on December 30, 2014 at 10AM, March 12, 2015 at 3PM and March 20, 2015 at 4PM. No participants were noted, and no concerns have been raised during the consultation. The Department intends to continue with appropriate and periodic consultation with the Tribal Health Directors and Business Council members as the program continues to move forward.

Program History

The Wyoming Department of Health (WDH), Division of Healthcare Financing (DHCF), the State appointed entity for administration of Wyoming's Medicaid program, is in the process of implementing a statewide Care Management Entity (CME) (e.g. a single prepaid ambulatory health plan (PAHP)) for youth with complex behavioral conditions. The PAHP shall support WDH's efforts to better serve youth in their homes and communities by providing the necessary services and supports. The PAHP will serve as an entry point for Wyoming's eligible youth with behavioral health needs so that the youth and their family can achieve the goals of safety, permanency, and well-being in their communities using high-fidelity wraparound (HFWA). HFWA is a community based delivery service model for Medicaid state plan targeted case management services composed of three (3) provider types who, collectively, are selected by and work with the youth and family team to accomplish clearly defined objectives and treatment goals. These provider types include the Family Care Coordinator, Family Support Partner and Youth Support Partner. The function of each provider type is detailed below:

Family Care Coordinator (FCC): Is responsible for implementing the phases and related activities of the HFWA service delivery process, advocating for and supporting the child/youth and family and coordinating the child and family team meetings, all required documentation and processes. The FCC is primarily responsible for the following functions:

I. *Maintaining open lines of communication between all team members;*
II. *Initiating and overseeing the completion of needed assessments and evaluations as identified by the team;*
III. *Facilitating the development of the individualized plan of care;*
IV. *Locating, arranging and referring the youth and family to direct services as identified in the individualized plan of care; and*
V. *Identifying when objectives in the plan are not being met, or identifying barriers to achieving the objectives and treatment goals of the plan of care.*

Family Support Partner (FSP): The FSP is a formal member of the wraparound team whose role is to serve the family, and help them engage and actively participate on the team, and make informed decisions to drive the HFWA process. The FSP does not provide clinical services, but rather the unique peer to peer support on their lived experience of raising and/or 2 years of work experience in programs serving populations with a child or youth with emotional, behavioral (including substance use), and mental health challenges.

The FSP should be well versed in the community, continuum of care, and the social contexts affecting wellness. The FSP may function as a mediator, facilitator, or bridge between families and agencies. FSPs ensure each family is heard and that their individual needs are being addressed and met. The FSP communicates with and educates child and family team members on wraparound principles, including family voice and choice, to ensure fidelity to the process.

Youth Support Partner (YSP): YSPs are young adults with personal experience participating in the system of care (mental health, special education, child welfare, juvenile justice) as a youth with behavioral health needs. YSP's may have experience overcoming various systems and obstacles related to seeking and maintaining recovery from their own behavioral health disorders. YSPs have the skills, training, and experience to perform the functions of their role.

Under contract with the Wyoming Department of Health, Division of Healthcare Financing, the PAHP will be responsible for coordinating the delivery of HFWA services (targeted case management provided via a HFWA delivery model), respite and youth and family training and support services (as detailed and outlined in the concurrent 1915 (c) Children's Mental Health Waiver).

Often times Medicaid youth with complex behavioral health conditions receive fragmented care due to the involvement of various public and private entities in service delivery, contributing to poor outcomes and unnecessarily high costs. Youth struggle because of gaps in required care coordination, family-disruption, and distant out-of-home placements. National and state spending on youth with complex behavioral health conditions is high. This is partially due to ineffective, uncoordinated, and/or inappropriate service delivery. By focusing on bridging gaps in service delivery and coordinating care, youth with complex behavioral issues will be better served, improving outcomes, while costs may also be reduced. Wyoming is striving to provide youth and their families the services necessary to allow the youth to reside in their community, participate in routine daily activities, and experience long term health and longevity.

Medicaid youth with Serious Emotional Disturbances (SED) and youth with a level of care that require a Psychiatric Residential Treatment Facility (PRTF) generally have more frequent emergency room visits, significantly higher utilization of psychotropic drugs at doses that often exceed national parameters, frequent disruption of family and youth resiliency, and higher service costs. With the various parties typically involved with these youth, and the potential of out-of-home placement, the WDH recognizes the need to

improve service delivery and increase the coordination of care for youth with SED in order to improve health outcomes, decrease recidivism, and contain costs. Effective July 1, 2016, WDH amended the contract and waiver language to include a payment methodology to make incentive payments to the PAHP for meeting specific metrics tied to outcomes achieved from successful care coordination that results in improved health outcomes, decreased recidivism and cost containment.

A. Statutory Authority

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

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

b. ___ **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
___ PIHP
_X_ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond

the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

___ FFS Selective Contracting program (please describe)

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

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

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

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

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

B. Delivery Systems

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

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

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

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

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

__X The PAHP is paid on a risk basis.
____The PAHP is paid on a non-risk basis.

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

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

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

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

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

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

1. **Assurances.**

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

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

Whenever possible, the PAHP will provide a choice of providers for each service. The PAHP will be required to develop a network of providers that meets the State's network adequacy requirements to ensure beneficiaries' ability to access services.

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

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X__ Other: (please describe) Individuals will be enrolled into one PAHP and given the choice of HFWA providers.

Enrollees will have free choice of HFWA (targeted case management provided via a HFWA delivery model) providers within the PAHP and may change providers as often as desired. The PAHP benefit package includes services as described in this waiver as well as youth and family training and support services detailed in the concurrent 1915 (c) Children's Mental Health Waiver. Any service required outside the scope of the PAHP will be provided via a qualified Medicaid-enrolled provider according to State Plan fee-for-service benefits.

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.

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

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

Through a competitive procurement process, the State has awarded a single PAHP contract for the administration and coordination of all services described herein. Under contract with the State, the PAHP will develop its provider network via contract execution with all willing and qualified agency or individual providers of family care coordination, family support, youth support, respite and youth and family training and support. As youth are determined eligible and enroll in the program, youth and families will have a choice of selecting from any provider within the PAHP's contracted network of providers. The PAHP will develop a service network State-wide and will be monitored for access and network adequacy by the State through strategies detailed in Section C of this waiver.

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

D. Geographic Areas Served by the Waiver

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

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

___ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
All 23 Counties in Wyoming	PAHP	Magellan Healthcare, Inc.

E. Populations Included in Waiver

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

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

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

_X_ Mandatory enrollment

___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

_X_ OTHER: TARGETING & MEDICAL CRITERIA FOR ALL INCLUDED POPULATIONS:

__X__ Former Foster Care Children are Medicaid beneficiaries listed in §1902(a)(10)(A)(i)(IX) of the Social Security Act.

_X_ Mandatory enrollment – if all targeting and medical criterion for program participation are satisfied.

____ Voluntary enrollment

__X__ Section 1915 (c) Children's Mental Health Waiver Participants are youth who applied and met all clinical and financial eligibility for participation in the State's Section 1915 (c) Children's Mental Health Waiver.

_X_ Mandatory enrollment

____ Voluntary enrollment

For ALL program Enrollees:

<u>Targeting Criteria - Initial:</u>

- *Medicaid youth ages 4-20 at risk of out-of-home placement (defined and identified as youth with two hundred (200) days or more of behavioral health services within one State fiscal year);or*

- *Medicaid youth ages 4-20 who currently meet PRTF level of care or are placed in a PRTF; or*
- *Medicaid youth ages 4-20 who currently meet acute psychiatric stabilization hospital level of care; had an acute hospital stay for mental or behavioral health conditions in the last 365 days; or are currently placed in an acute hospital stay for mental or behavioral health conditions; or*
- *Youth enrolled on the Children's Mental Health Waiver (section 1915(c) WY Waiver # 0451); or*
- *Medicaid youth ages 4-20 referred to the PAHP (who meet defined eligibility, including clinical eligibility and SED criteria).*

Medical Eligibility Criteria – as a condition for enrollment after initial targeting criteria is met:

- *Youth ages 6-20 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20), and youth ages 4 & 5 must have an Early Childhood Service Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service needs; and*

- *Must have a DSM Axis 1 or ICD diagnosis that meets the State's diagnostic criteria.*

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.

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

_X__ Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
Program for All-Inclusive Care for the Elderly (PACE)

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

__X_ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
Excluded populations are those youth who are actively enrolled with the following waivers, or who have met all clinical criteria for and have been placed on a waitlist for the following waivers:

- *Children's Developmental Disability Waiver – WY Waiver 0253*
- *Acquired Brain Injury (ABI) – WY Waiver #0370*
- *Developmental Disability Supports Waiver – WY Waiver # 1060*
- *Developmental Disability Comprehensive Waiver – WY Waiver # 1061*
- *Long Term Care Waiver – WY Waiver # 0236*
- *Assisted Living Facility Waiver – WY Waiver #0369*

___ 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.

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

_X__ **Other** (Please define): *Any other youth, upon application, whose primary need is determined to be for services that are more habilitative in nature vs. the intensive rehabilitative nature of HFWA (targeted case management provided via a HFWA delivery model) services. This need will be determined by a level of co-*

occurrence indicated as "4" or "5" in Dimension III on the CASII or a rating of "4" or "5" on the ECSII assessment, section IV.

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.

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

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

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):

_X__ Family planning services are not included under the waiver.

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

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
___ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that

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

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

_X_ Other: Not applicable: *FQHC services are not a component of the waiver program. Therefore, services provided as these sites will not impacted or otherwise restricted through the implementation of the PAHP (this waiver 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.

Respite Services:

Please refer to the Cost Effectiveness Section of this waiver for expenditures specific to the (b)(3) services.

Populations Eligible: Any individual enrolled with the PAHP who meets eligibility criteria as outlined in Section A. Part I.E.1. The (b)(3) services will be available to all eligible enrollees of the PAHP (to include State Plan qualifying youth as well as those enrolled and receiving services through the State's concurrent 1915 (c) waiver).

Provider Type: Appropriately trained, credentialed and Medicaid-enrolled Respite providers contracted with the PAHP as part of the PAHP provider network for the provision of Respite services.

Geographic Availability: The PAHP contract will ensure Respite is available to all enrolled youth statewide.

Reimbursement Method: The PAHP will provide access to and payment for the respite services under a separate capitated rate up to the financial limits of this section 1915 (b) waiver.

Service Description: Respite service is intended to be utilized on a short-term, temporary basis for an unpaid caregiver to provide relief from the daily burdens of care and should be primarily episodic in nature. Respite care cannot be used to substitute for care while the primary caregiver is at work or during services otherwise available through public education programs, including education activities and after school supervision.

Respite services shall accommodate the needs of the participant/family. The respite site and services shall match the identified needs of the participant and family. Respite and its intent to support primary high fidelity wraparound (targeted case management provided via a HFWA delivery model) (HFWA) services are outlined in the person's plan of care prior to services being authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Location: Service settings are either based in the provider's residence, the participant's residence, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers. Respite providers shall have their family home approved to provide services to the participant instead of or in addition to providing services in the participant's family home or the community settings. While outings to community locations are acceptable, these settings should not be the core location of services.

Provider/Youth Ratio: Respite can only be provided for one participant at a time, without PAHP review and approval. Only unique and exceptional circumstances would be considered in providing services for more than one participant.

Frequency/Duration: Respite service will be restricted to a maximum of 416 hours per calendar year for each enrolled and qualified participant. The PAHP, via approval of the plan of care, will control the distribution of units on a monthly basis dependent on the needs of the youth/family.

Provider Qualifications:

It is the responsibility of the PAHP to provide respite care via their provider network.

Certificate (specify): Any provider of respite services is required to attain and maintain a certification for this service from the PAHP, and meet all specified State criteria listed below:

- *Successfully complete a Criminal history Background check, which includes a Central Registry, Federal Bureau of Investigations (FBI)/Division of Criminal Investigation (DCI), and Office of Inspector General (OIG) background screening; and*
- *Maintain a current CPR & First Aid Certification.*

Other Standards (specify):

- *At least 21 years of age (proof required); and*
- *Two years work/personal experience with children (preference given to individuals who have worked with a child with serious emotional disturbance);*
- *Maintain current auto insurance if transporting PAHP enrollees/youth; and*
- *Demonstrate competency in the following areas: experience and training in managing youth/ children with SED and knowledge of behavior management and development issues.*

Verification of Provider Qualifications:

It is the responsibility of the PAHP to ensure all provider qualifications, both upon initial contracting with the PAHP and annually thereafter.

Frequency of Verification:
PAHP initially certifies an individual providing this service for one year and annually thereafter.

A respite provider determined to be out of compliance with state requirements at any point in the year may receive notification from the PAHP regarding the nature of the non-compliance issue and a specified timeframe for resolution. The PAHP has the authority to monitor individuals at any time during service delivery if there has been any of the following:

- *A complaint filed against the respite provider via the PAHP's complaint/ grievance process;*
- *An incident report filed via the PAHP's incident reporting process; and/or*
- *There is indication the individual is not complying with the rules and regulations.*

7. **<u>Self-referrals</u>.**

___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. **<u>Details for 1915(b)(4) FFS selective contracting programs</u>:** 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.

The PAHP benefit package is limited to community based high fidelity wraparound (targeted case management provided via a HFWA delivery model) services and respite for all enrolled youth, as well as youth and family training and support services provided to youth enrolled through the concurrent 1915 (c) Children's Mental Health Waiver. Each enrollee maintains full access to all Medicaid state plan services. Special health care needs will continue to be identified and treated through primary and specialty care providers in Medicaid FFS.

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 accordance 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.

3. **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**.

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

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

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

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

___ 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):

1. **Assurances For PAHP program.**

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

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

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

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

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

   A. ___ Initial credentialing

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

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

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

5. ___ Has an initial and re-credentialing 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):

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

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

2. _X_ 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.

The PAHP is allowed to attend health fairs, sponsor community forums, radio spots, print media, etc., and provide general outreach so long as the entity does not target its materials directly to Medicaid beneficiaries.

3._X__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.

HFWA Youth and Family Handbooks are issued to those automatically referred to the PAHP. Handbooks will outline all Federal program requirements and include references to HFWA educational material that may be helpful to families when being assessed for enrollment. Marketing material can also include information on anticipated impacts and goals of the program.

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

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

Because there is no choice of PAHP, the State prohibits gifts and incentives to Medicaid beneficiaries.

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. _**X**_ 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, within its contract with the PAHP, must make all program handbooks, enrollment and other marketing materials available in both English and Spanish.

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._X_ The languages comprise all languages in the service area spoken by approximately _4.0__ 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): *Spanish*

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 _4.0__ 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 State has an active contract with Passport to Languages, an interpretation company capable of providing services for over 70 different languages. If a client or provider needs services, he or she can call to set up an appointment time and Passport to Languages will bill the State directly for the provided services.

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

All marketing and education materials will be available in prevalent languages as defined above. For other language needs, the State has an active contract with Passport to Languages, an interpretation company capable of providing services for over 70 different languages. If a client or provider needs services, he or she can call to set up an appointment time and Passport to Languages will bill the State directly for the provided services.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
_X__ Contractor (please specify): __PAHP_____

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

c. Enrollee Information

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

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

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

___ 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):

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

The State has developed a process for auto-referring youth who meet the initial Targeting Criteria identified in Section A. Part I E. Upon referral of a youth who is determined to meet the initial Targeting Criteria as detailed in Section E. "Other", each youth and family will then be contacted by the PAHP for distribution of a list of Medicaid enrolled assessment providers to schedule a third party independent assessment (CASII/ECSII) as part of the medical eligibility determination. These third party assessments for confirmation of medical eligibility are billed FFS to the State and not incorporated into the PAHP's responsibility. This process ensures conflict free eligibility determinations and case management procedures.

Once the assessment is complete, the family and youth will provide a completed copy of the assessment and score to the PAHP, in addition to clinical documentation from a qualified licensed mental health professional confirming the presence of an Axis 1 diagnosis and that the youth meets the federal qualifying criteria for a youth with serious emotional disturbance (SED). The youth/family may also provide appropriate authority for the evaluator to provide the assessment and results directly to the PAHP contractor. The submission of these components to the PAHP will serve as confirmation of medical eligibility for PAHP enrollment. The PAHP will maintain copies of the assessments and documentation for State review during periodic quality assurance audits. Each youth must meet minimum score criteria in order for the PAHP to enroll.

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

_X_ 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.):
September 1, 2015, the program will be implemented statewide. The State will begin its auto-referral process of youth who meet the initial targeting criteria. The PAHP will begin contacting youth and families to schedule the third party assessments in order to evaluate the youth's eligibility against the program's medical eligibility criteria (assessments include CASII/ECSII, confirmation of Axis 1 diagnosis and SED by a licensed

mental health professional). As soon as the assessments confirm qualifying scores and criteria for medical eligibility, the PAHP will enroll the youth.

___ 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.

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

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

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

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

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

ii.**_X_** The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or dis-enrollments.

Disenrollment for enrollees requested by the PAHP will be reviewed and approved by the State based on the medical necessity of the HFWA service plan. An individual may be dis-enrolled from the PAHP if:

a) Youth is no longer Medicaid eligible;

b) Youth moves out of state;
c) Youth ages out of the program;
d) Youth is incarcerated;
e) Youth is no longer financially eligible;
f) Youth is no longer clinically eligible;
g) Youth is determined eligible for any excluded program/population (as detailed in Section A. Part I E, Excluded Populations); or
h) Youth is in an out of home placement longer than 180 days.

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.

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

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

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

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

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

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

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

b. **Timeframes**

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

___ The State's timeframe within which an enrollee must file a **grievance** is 180 days.

c. **Special Needs**

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

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

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

_X_ The grievance procedures is operated by:

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

_X_ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals). *The PAHP must have a system in place for enrollees or providers acting on behalf of enrollees that include a grievance process, an appeal process, and access to the Agency's fair hearing system. The grievance process will be approved by the State and monitored quarterly. Enrollees who are dissatisfied with the outcome of a grievance filed with the PAHP have a right to appeal to the State. Information sent to enrollees will include processes and details for accessing/filing a grievance and appeal.*

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

_**X**_ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: (please specify for each type of request for review)
Thirty (30) days

_**X**_ Has time frames for resolving requests for review. Specify the time period set: (Please specify for each type of request for review)

The PAHP must acknowledge the receipt of a complaint received by an enrollee, the State or provider within five (5) working days.

The PAHP needs to prepare and present a proposed resolution to the issue reported within forty-five (45) calendar days from the date the PAHP receives the grievance. If the PAHP's proposed resolution is not accepted by the individual or entity acting on their behalf, the PAHP then has thirty (30) calendar days to review and respond to the appeal.

_**X**_ Establishes and maintains an expedited review process for the following reasons: *For cases in which the individual or entity acting on their behalf demonstrates that the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.*

Specify the time frame set by the State for this process: *The PAHP must propose a resolution and provide notice no later than three (3) working days after receipt of the complaint. A fourteen (14) calendar day extension may be granted by the PAHP or the State if the individual or entity acting on their behalf requests and/or agrees an extension is necessary for consideration of the proposed resolution.*

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

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

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

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

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

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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

Plan												
Ombudsman												
On-Site Review												
Performance Improvement Projects												
Performance Measures	X	X	X	X	X	X	X	X	X	X	X	X
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review	X	X	X	X			X		X	X	X	X
Other: (describe)												

II. Details of Monitoring Activities

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

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

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

a. _X___ 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)

_X__ NCQA
_X__ JCAHO
___ AAAHC
_X__ URAC
_X__ Other (please describe): Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF)

- *Applicable program: PAHP*
- *Personnel responsible: State*
- *Detailed description of activity: If the PAHP selected through the competitive procurement meets NCQA, JCAHO, URAC, CARF, or COA accreditation standards for accreditation, the state will deem that the state-specific standards required in 42 CFR 43 Subpart D are met*
- *Frequency of use: Once, upon PAHP selection/initial contracting*
- *How it yields information about the area(s) being monitored: Accreditation information is used to monitor the following: timely access, provider selection, and quality of care.*

The accreditation will be utilized to ensure the quality and effectiveness of the services provided. After review of the result accrediting body survey results, the

State may require a written plan for addressing low performance. Accreditation results may be reported and reviewed by the State and the results reviewed as part of the EQR process. A corrective action plan may be requested by the State.

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

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

c. _**X**_ Consumer Self-Report data

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

- *Applicable program: PAHP*
- *Personnel responsible: State and PAHP*
- *Detailed description of activity: The State will conduct a consumer satisfaction survey for its enrolled population, which may slightly vary from the existing satisfaction tools. The survey will utilize the sampling method and format defined by the National Committee for Quality Assurance (NCQA).*
- *Frequency of use: The consumer satisfaction/disenrollment survey will be conducted annually. A random sample for each survey is drawn from Medicaid enrollees who received a covered service in the previous year.*
- *How it yields information about the area(s) being monitored: The survey information is used to monitor the following: disenrollment, timely access, information to beneficiaries, and quality of care.*

The survey results must be submitted to the State. Findings from the results will be utilized to measure and evaluate the client's perception of the quality and effectiveness of services received and to evaluate reasons for disenrollment from the program. Results will assist the State in monitoring the satisfaction of participants, identify gaps in service and evaluate needs in future policy development. The survey will include the following demographic information: 1) provider/agency in which services are being received; participant's age, gender, race or ethnic group; and modalities of services received during HFWA (targeted case management provided via a HFWA delivery model).

This information will be utilized to identify issues for performance measures regarding quality of care and to improve the consumer information for member use. After reviewing the results from the satisfaction survey, the State may require a written plan for addressing low performance. Survey results are

reported and reviewed by the State. The findings are included in the PAHP's performance evaluation.

d. _**X**_ Data Analysis (non-claims)

_X_ 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: PAHP*
- *Personnel responsible: State and PAHP*
- *Detailed description of activity: The PAHP is required to track disenrollment requests by enrollee from the plan, denials or referral requests, and grievance and appeals data. This data is included in a quarterly report from the PAHP to the State.*
- *Frequency of use: Data is gathered and reported quarterly with quarterly reviews by the State.*
- *How it yields information about the area(s) being monitored: The data is used to monitor the following: quality of care, enrollment/disenrollment, coordination/continuity, coverage/authorization and grievances*

The data is integrated into the performance measures as part of the overall State performance improvement process. The data is analyzed to identify trends, sentinel and adverse events. The findings are reported to the State. The State then discusses the findings to identify opportunities for improvement. In addition, this information is used to assess the effectiveness of quality initiatives or projects. The findings are included in the PAHP's performance evaluation.

e. _**X**_ Enrollee Hotlines operated by PAHP

- *Applicable program: PAHP*
- *Personnel responsible: PAHP and State*
- *Detailed description of activity: The PAHP is required to have staff available by 800 number 24 hours a day/365 days a year to respond to enrollee calls. Interpreter services are available for the hearing impaired and for non-English speakers. Calls range from non-urgent requests for referral to behavioral health crises. The 800 number is printed in the enrollee benefit book and associated materials. The 800 number shall include telephone crisis intervention, risk assessment, and consultation to callers which may include family members or other community agencies regarding behavioral health services.*
- *Frequency of use: The 800 number is available 24 hours a day, every day.*

- *How it yields information about the area(s) being monitored: The 800 number is used to monitor the following: information to beneficiaries, grievance, timely access, coordination/continuity, and quality of care*

The data is used to monitor the above topics by obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends. If deficiencies are noted the Contractor must perform corrective action until compliance is met. Issues are reported to the State quarterly and the State discusses the findings to identify opportunities for improvement. The findings are included in the PAHP's performance evaluation.

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

g. _**X**_ Geographic mapping of provider network

- *Applicable program: PAHP*
- *Personnel responsible: PAHP*
- *Detailed description of activity: Through geographic mapping, distribution of provider types across the state is identified. A full listing is included in the Service Report.*
- *Frequency of use: Geographic mapping is generated and reported on a quarterly basis.*
- *How it yields information about the area(s) being monitored: Geographic mapping information is used to monitor marketing, information to beneficiaries, PCP/Specialist Capacity, choice, timely access, coordination/continuity, coverage/authorization, quality of care and Provider Selection. Referral and subsequent enrollment patterns can be mapped to ensure appropriate marketing in all geographic areas.*

A software program produces a report that is analyzed for compliance with the State access and capacity requirements. The analysis is part of the PAHP's performance evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

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

- *Applicable program: PAHP*
- *Personnel responsible: An independent third party will be contracted to*

perform this activity/audit.

- *Detailed description of activity: The State will hire an independent assessor to assess quality of care, access to services, and cost-effectiveness of this new HFWA (targeted case management provided via a HFWA delivery model) delivery system as required by the waiver.*
- *Frequency of use: Biannually for the first two waiver periods.*
- *How it yields information about the area(s) being monitored: The independent assessment will be used to monitor timely access and quality of care.*

The assessment is used to monitor the above topics. The data collected is used to 1) analyze the effectiveness of the new program; 2) develop a quantitative understanding of access to the new behavioral health care service delivery system; 3) identify needs for further contracting; and/or 4) identify processes and areas of quality of care for detained study through on-going performance measures. The analysis is part of the PAHP's evaluation. The State discusses the findings to identify opportunities for improvement and if deficiencies are noted the Contractor must perform corrective action until compliance is met.

i. **X** Measurement of any disparities by racial or ethnic groups

- *Applicable program: PAHP*
- *Personnel responsible: PAHP*
- *Detailed description of activity: The PAHP is required to report demographic data (including racial/ethnic data), outcomes measures, utilization and special needs population (target population) data to the State.*
- *Frequency of use: The data is collected annually.*
- *How it yields information about the area(s) being monitored: The measurement of any disparities by racial or ethnic groups will be used to monitor timely access and coverage and authorization of care.*

The disparity analysis provides information regarding the effectiveness of the program. This information is utilized for performance measures. The primary focus is to obtain information about problems or opportunities for improvement to implement performance measures for quality, access, or coordination of care or to improve information to beneficiaries. The findings are included in the PAHP's performance evaluation.

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

- *Applicable program: PAHP*
- *Personnel responsible: PAHP*
- *Detailed description of activity: The PAHP submits documentation to the State that it offers timely access to, coordination/continuity of*

services and appropriate range of services adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees.

- *Frequency of use: Documentation is submitted quarterly.*
- *How it yields information about the area(s) being monitored: Network*

The data collected is used to monitor the waiver areas of timely access and coordination/continuity. By obtaining information from the beneficiaries, resolving issues, and identifying and addressing trends, the State will use this reporting mechanism to document and evaluate overall network adequacy. If deficiencies are noted the Contractor must perform corrective action until compliance is met. The findings are included in the PAHP's performance evaluation.

k. _____ Ombudsman

l. _____ On-site review

m. _____ Performance Improvement projects [**Required** for MCO/PIHP]
_____ Clinical
_____ Non-clinical

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 program: PAHP*
- *Personnel responsible: PAHP And State*
- *Detailed description of activity: The State has established a comprehensive list of performance measures, entitled Startup Requirements, Operational Requirements, and Outcome Measurement and Credits.*
- *Frequency of use: The performance measures are reported on quarterly, or as otherwise stated in the Requirements.*
- *How it yields information about the area(s) being monitored: The performance measures provide information on all listed categories.*

Data on performance measures is reported to the State quarterly or as otherwise listed in the contractual requirements negotiated between the State and the PAHP contractor. The quarterly reports to the State aid in the identification of

opportunities for quality improvement and the assessment of initiative effectiveness. The contract also establishes expectation around continuous quality improvement that includes participating in the development of measures of performance and collecting and reporting baseline data on identified performance indicators, and development and implementation of improvement plans. The results are reported to the State and the State discusses the findings and identifies opportunities for improvements. In addition, this information aids in the assessment of the effectiveness of the quality improvement process. The data from all sources is analyzed for compliance. The identified aspects are integrated into the implementation of continuous quality improvement processes. The findings are included in the PAHP's performance evaluation.

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

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

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

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

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

- *Applicable program: PAHP*
- *Personnel responsible: PAHP*
- *Detailed description of activity: The PAHP conducts a statistically valid sample review. The Contractor shall perform ongoing monitoring of utilization management (UM) data, on site review results, and claims data review. The designated IT staff will review the Contractor's utilization review process.*
- *Frequency of use: Utilization reviews occur at intervals, first within the initial treatment period and then regularly thereafter. Data related to the utilization review are reported to the State and reviewed annually at minimum.*
- *How it yields information about the area(s) being monitored: Utilization management data can be used to monitor program integrity, choice, marketing, enrollment/disenrollment, timely access, coordination/continuity, provider selection, quality of care and coverage/authorization.*

Data is utilized to indicate opportunities for improvement and to assess compliance with utilization policies and procedures at the provider and contractor level. This information is primarily used for provider and enrollee monitoring. The analysis is reported to the State. The State discusses the findings

to identify opportunities from improvement and, if areas of improvement are noted, the Contract works with the specific provider noted or incorporates the identified aspects into the implementation of performance measures. The findings are included in the PAHP's performance evaluation.

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.

_**X**_ 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.

___ This is a renewal request.

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

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

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

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes

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

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: Matt Hager

c. Telephone Number: 307-777- 6099

d. E-mail: Matt.Hager@wyo.gov

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

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

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

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

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

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

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

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

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

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

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

a.___ MCO
b. ___ PIHP
c. _**X**_ PAHP
d.___ Other (please explain):

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

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

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a. _**X**_ Population in the base year data

1. ___ Base year data is from the same population as to be included in the waiver.
2. _**X**_ 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.)

Due to the void in cost experience under a fee-for-service environment for targeted case management services delivered through HFWA, the State is using and applying the service utilization experience from the current 1915 (c) Children's Mental Health Waiver (CMHW) youth for development of all cost assumptions and projections. In comparing the two populations of youth, similarities exist supporting the State's request for consideration of the proxy:

I. Clinical qualifications – both the CMHW and PAHP youth are required to meet standard clinical eligibility guidelines; 1) Youth ages 6-20 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20), and youth ages 4 & 5 must have an Early Childhood Service Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service needs; and 2) Must have a DSM Axis 1 or ICD diagnosis that meets the State's diagnostic criteria.

II. Ages served – both the CMHW and PAHP serve youth between the ages of 4 and 21.

III. Providers – Most of the current CMHW providers will also be providers under contract with the PAHP.

IV. Services – both the PAHP and CMHW focus on family care coordination as the central service of support available to enrolled youth and families. Both programs utilize HFWA principles and practices for delivering services. Under the 2013 CMHW, Youth and Family Training and Support Services paralleled services that will now be Family and Youth Peer Support in the PAHP. Additional services are currently being built out under the PAHP to fully

operationalize all three prongs (provider types and service delivery model components) of HFWA.

V. Geography – The CMHW is currently available state wide, but enrollment and participation is limited to seventy-five (75) youth at any given time. The PAHP will also be statewide.

The State has also worked to identify any program differences that may lead to unintended variation in service utilization between the two groups. While some program components between the 2013 CMHW and the PAHP are different, the State has not identified any difference projected to result in service utilization variation between program groups. Differences identified include:

I. Financial Eligibility – the current financial eligibility and income requirements between the two programs are different. The PAHP will service youth who are eligible for Medicaid through an existing state plan eligibility group and the CMHW will serve youth up to 300% of the SSI income level without regard to parent/guardian income. The State has no evidence to support a difference in financial eligibility criteria leading to service utilization variances between youth.

II. Providers – while most CMHW providers also work under contract with the PAHP, the waiver does have a few independent providers not affiliated. The State has no evidence to support a difference in agency vs. independent provider choice leading to service utilization variances between youth.

b._X__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.

The State anticipates enrollment to flatten at approximately 40% of those youth identified to meet initial program targeting criteria (600 in SFY2013). The demographic and transient nature of Wyoming's Medicaid population in general has made it difficult to locate and contact youth/families referred to the existing pilot program. Once initial contact is made for program participation, confirmation of clinical and financial eligibility criteria has not exceeded 40% under the current pilot. The State anticipates this same trend to continue.

Definitions:

MEG1 – State Plan Enrolled Youth: *This group includes all Medicaid State Plan eligible youth based on an analysis of prior state plan service utilization against program criteria. The benefit package for this MEG includes targeted case management (TCM) delivered through a high fidelity wraparound model (family care coordination, family support services, and youth support services) and respite.*

*Base year member months = (600 eligible youth **X** 40% projected enrollment rate = 240 youth) **X** 12 projected member months per youth =* ***2,880 SFY2013 base member months***

MEG2 – 1915 (c) Enrolled Youth: *This group includes all youth qualifying for services through Wyoming's existing 1915 (c) Children's Mental Health Waiver. The benefit package for this MEG includes targeted case management (TCM) delivered through a high fidelity wraparound model (family care coordination, family support services, and youth support services), youth and family training and support services and respite.*

The base year member month for MEG2 - 1915 (c) Enrolled Youth is 782. This metric comes directly from SFY2013 enrollment data.

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

September 1, 2015, the new PAHP contractor will be assuming enrollment of all current program participants (under the current contractor) as well as all youth enrolled in Wyoming's section 1915 (c) Children's Mental Health Waiver. The state funded pilot program has been operational in only the seven southeast counties of the State. The initial program population, to include both Medicaid State Plan and section 1915 (c) waiver youth is projected to be 175 youth in P1, Q1 (100 youth enrolled through Medicaid State Plan and 75 1915 (c) waiver youth).

MEG 1 P1, Q1 = 100: 100 youth based on 1 month in Q1 with a September 1, 2015 implementation date. This projected reflects current enrollment rates moving in to the September 1 assumption of service delivery by the PAHP.

MEG 2 P1, Q1 = 75: 75 youth max waiver capacity based on 1 month in Q1 with a September 1, 2015 implementation date.

Moving forward, for the MEG1 group the average experienced enrollment rate has been 7-9 youth/ month. The State has added 9 youth per month (or 28 per quarter) to the total member months calculated if Q1 had been

a 3 months (increase of 228% P1, Q2; 8.5% P1, Q3; 7.9% P1, Q4; 7.3% P2, Q1; 6.8% P2, Q2; 6.4% P2, Q3; 6.0% P2, Q4; 5.6% P3, Q1; 5.3% P3, Q2; 5.1% P3, Q3; 4.8% P3, Q; 4.6% P4, Q1, 4.4% P4, Q2; 4.3% P4, Q3 each quarter) to the projected member months up to a maximum of 240 youth for MEG 1 (40% of the 600 eligible youth) identified in the base year as meeting the program's current initial targeting criteria. In Appendix D1, only the MEG1 group is shown to increase in enrollment, as it's assumed the MEG2 will remain constant at the maximum waiver capacity (75 youth).

The State is projecting an enrollment rate no more than 40% of potential State Plan youth due to the demographic and transient characteristics of the Medicaid population in general. The State anticipates that some youth will have relocated out of state, the PAHP will be unable to locate some for additional medical eligibility assessments, or the youth will not meet the medical eligibility criteria as established in this waiver. Year four enrollment projections are estimated to become relatively flat in Q4 due to the short term targeted intervention nature of the program. The program is not a permanent, long term service solution. As youth no longer meet medical eligibility criteria for participation, they will be dis-enrolled while other newly identified youth are enrolled.

It is the State's expectation that with the marketing and promotion of the delivery model to the targeted population state-wide, overall acceptance of and participation in the program will increase the total member months by the addition of 7-9 youth/ month to the MEG1 population, to a projected maximum of 40% enrollment of State Plan youth (240 X 12 months) and 75 waiver youth (75 X 12 months) for a total of 3,780 member months per year when both programs are functioning at the projected capacity.

The member month trend projected for MEG2 is consistent with current approved waiver capacity. At maximum capacity, the waiver can only serve 75 youth at any one time, with the exception of P1 which has been prorated to account for the 1 month of program implementation. For SFY 2013, there were 782 member months. This trend remains consistent across the four program years, but is slightly higher than base year data. The waiver, in SFY2013 was not operating a full capacity due to budgetary restrictions. However, with the new PAHP contractor on board and program realignment with the PAHP, the State anticipates maximizing waiver utilization and serving 75 youth at a time throughout the year. The P1 – P4 anticipated member months across all four program years is 225 (75 youth multiplied by 12 months/ 4 quarters) with the exception of P1, Q1 given the 1 month quarter versus a traditional 3 month quarter.

d. _**X**_ [Required] Explain any other variance in eligible member months from BY to P2: *No other variance aside from the conditions details in "c." are anticipated.*

e. _**X**_ [Required] List the year(s) being used by the State as a base year: *2013.* If multiple years are being used, please explain:_____

f. _**X**_ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. *The base year is SFY.*

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

CMS requirements for appropriate FMAP disbursement for PRTF services require that the placement recommendation (level of care) be made a qualified medical clinician. Prior to July 1, 2013, the State often found that PRTF placements were being made at the direction of the court (judge or attorney) or the Department of Family Services case worker. For this reason, and to remain compliant with CMS requirements for FMAP, the State funded these placements independently and paid them outside of the MMIS. July 1, 2013, Wyoming Statute was enacted that made it illegal for a court (judge, attorney) or other affiliated party to request a specific level of care or name a specific PRTF for placement. The level of care required for appropriate clinical treatment now has to be recommended by a qualified medical clinician. However, for purposes of calculating rates and assessing total cost information and projected savings, these youth (even while funded via state money) would qualify for participation in the current PAHP program. Therefore, their placement expenditures were added to the claims data pulled from the MMIS. In SFY2013 (base year data for cost effectiveness demonstration) the total amount paid for PRTF placements under the general fund budget was $4,378,310.00.

For Conversion or Renewal Waivers:

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

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

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

_____

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

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

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

For Initial Waivers:

a. _**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.

The contracted per member per month rate for each MEG is as follows:

MEG1- State Plan Enrolled Youth: Family Care Coordination, Family Support, Youth Peer Support and Respite

MEG2 - CMHW 1915 (c) Enrolled Youth: Family Care Coordination, Family Support, Youth Peer Support, Youth and Family Training and Support and Respite.

Targeted case management services, in the form of high fidelity wraparound (HFWA) will be included in the capitated rate, in addition to respite as a (b)(3) service and youth and family training and support to a subset of the program's total enrolled population receiving services under the 1915 (c) Children's Mental Health Waiver. The State anticipates the following approved state plan services to be impacted by this program:

- *Inpatient Hospital (includes psych and PRTF)*
- *Mental Health Facility*
- *Physician Services (includes psych)*
- *Outpatient hospital (includes psych)*
- *IHS Outpatient*
- *Prescribed Drugs*
- *Other Practitioners (includes psych)*
- *Clinic Services*
- *EPSDT Screening*
- *Rural Health Clinic*
- *FQHC*
- *Tribal 638*

For purposes of determining the Actual Waiver cost (D3 of the workbook), the State included all State Plan services incurred during SFY2013 for the youth identified for expected enrollment (240 state plan plus 75 waiver).

Calculation: Total SFY 2013 Medicaid spend of $26,246,619 for all 600 initial youth identified X 40% maximum enrollment = $10,498,647.60 + (SFY2013 1915 (c) waiver expenditures of $1,414,981) = $11,913,628.80.

For P1, this amount has been multiplied by 5/6 to account for a 10-month initial program year. All figures calculated for P2 – P4 assume a 12-month year and all trend and program adjustments were applied to the full 12-month expenditure calculation.

For Conversion or Renewal Waivers:

a.___ [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**:

_____

b.___ [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: _____

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

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

For Initial Waivers:

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

There is a growing body of evidence indicating that the system of care approach is also cost effective and provides an excellent return on investment. The emerging data, mostly obtained from analyses conducted by states and counties themselves, along with several multi-site studies, demonstrate a return on investment that can be quantified in terms of cost savings both currently and in the future. In most cases, net cost savings are derived from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and other group care, even when expenditures increase for home- and community-based care and care coordination. Cost savings are also derived from decreased involvement in the juvenile justice system, fewer school failures, and improved family stability, among other positive outcomes.

The national evaluation of SAMHSA's Children's Mental Health Initiative grants found that children and youth served with the system of care approach were less likely to receive psychiatric inpatient services (ICF International, 2013). From the 6 months prior to intake to the 12-month follow-up, the average cost per child served for inpatient services decreased by 42%. These youth were less likely to visit an emergency room (ER) for behavioral and/or emotional problems, and, as a result, the average cost per child for ER visits decreased by 57%. These youth were also less likely to be arrested, with the average cost per child for juvenile arrests decreasing by 38%.[1]

Page 9 of this publication, "Highlights of Cost Savings from State and Local Systems of Care" detail the experienced cost savings specific to wraparound initiative nationwide (page 11). The research details specific cost reductions experienced to net Medicaid spending as a result of (mostly) reduced ER utilization and reduced PRTF placements. For purposes of calculating the anticipated State Plan Service savings, the State utilized the median net reduction percentage supported by national experience with similar projects in other states.

In its development of the PMPM cost savings, the State applied the following methodology:

Step 1: Literature references indicate other comparable programs achieve a 50-60% reduction in state plan services costs through the implementation of a robust intensive care coordination (i.e. high fidelity wraparound services delivery model) program. As a conservative measure, the State initially reduced this original projection by 52% to arrive at the maximum savings percent projected to be obtainable by year 4 (P4, 29%). To allow for year over year scalability, the State lowered this projected savings in P1 to account for new program ramp up (to mirror the trends calculated in member month enrollment). See Line 3 below.

Step 2: Program adjustment. To account for the following differences in Wyoming's program compared to other national demonstrations, an additional 50% adjustment was applied (line 4);

- *Limited benefit package – only including targeted case management, respite and youth and family training and support (for 1915 (c) enrolled youth only)*
- *New program – limited cost experience with this service package*
- *Under-developed provider network and capacity – the program is*

[1] Return of Investment in Systems of Care for Children with Behavioral Health Challenges, 2014. http://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf

moving from the 7 southeast counties of the state to a statewide model

- *Geography – Wyoming, in its entirety, is a rural frontier State and program leaders acknowledge the challenges with service delivery and provider network development in the more remote communities*
- *New service delivery model – the PAHP will be training new providers for service delivery, to include the two new provider types (Family Support Partner and Youth Support Partner)*
- *In its shift from the pilot to a statewide program, program managers tightened the provider training and credentialing process to ensure fidelity to the delivery model*

Step 3: P1 of program implementation will be a 10-month year based on effective date. Total expenditures have been prorated to account for only 10 months of costs versus 12. P2 – P4 figures have been calculated to assume a 12 month program year.

The projected PMPM savings resulting from the decrease in spending on Medicaid state plan services was calculated using the following methodology, as illustrated in Table X, below:

Table X: *Calculation of gross PMPM savings*

Line	Item	Base	P1	P2	P3	P4
1	Member Months enrolled	3662	1918	2717	3164	3612
2	Member Months enrolled (% of base)		52%	74%	86%	99%
3	Assumed savings percent (literature)		23%	26%	29%	29%
4	Program Adjustment (limited benefit plan)		50%	50%	50%	50%
5	Effective savings (Line 2 x 3 X 4)		6.02%	9.65%	12.53%	14.30%
6	Total base cost (.5% inflation)	$11,913,629	$9,977,664	$12,033,063	$12,093,228	$12,153,695
7	Estimated savings (Line 5 x 6)		$600,975.81	$1,160,622.13	$1,515,054.98	$1,738,223.92
8	PMPM Savings (Line 7 / Line 1)		$313.33	$427.17	$478.84	$481.24

Step 1: The percent of member-months from the base population that will be enrolled in the program in each year assumed to be 65% in P1, 91% in P2 and full enrollment (plus additional growth) in P3 and P4.

Step 2: The estimated effect of the program in terms of savings on other State Plan services was a 29% decrease. This came from the midpoint of what is shown in the literature. However, another ramp in program effectiveness is assumed, beginning with 23% savings in P1 up to 29% in P4.

Step 3: The estimated savings by year is multiplied by the estimated percent of children enrolled in the program each year and multiplied by the program adjustment (Line 2 multiplied by line 3 multiplied by Line 4) to generate an effective annual savings percentage. The estimated savings for P1 was then multiplied by (10/12) to account for the shortened program year.

Step 4: The base cost for the comparison population ($11.9 million) is projected through P4 using a 0.5% inflation assumption. The inflation amount was calculated based on a 12 month P1 program year to prevent any understatement of additional costs.

Step 5: The estimated total dollar value of savings is calculated by multiplying the effective savings percent by the estimated cost in each year.

Step 6: The PMPM savings are calculated by dividing the total savings by the number of member months enrolled in the program.

Appendix D5 has been updated with the following methodology to demonstrate the projected savings in state plan services is sufficient to fund the additional administrative costs (all costs projected to be in addition to $21.75 from base year calculations) and (b)(3) service cost as follows:

The State has added Column N to Appendix D5. The numbers reflected in N12, N13, N27, N28, N39, N40, N50 and N51 and are the calculated reduction amounts expected in state plan savings year over year. The number is reflected as a negative offset to the program administrative and (b)(3) service costs. P2-P4 figures have been adjusted to only account for any increased savings from year to year, and to prevent any artificial deflating of State Plan expenses.

The State assures CMS that while the same calculated annual savings are reflected in both the table below and the (b)(3) service costs table, the total projected reductions are not duplicative, but simply an aggregate savings calculated sufficient in amount offset both the administrative expense and the (b)(3) service costs.

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
PAHP Program Implementation	*P1 = $313.33 PMPM (N12 and N13, Appendix D5)*		

	P2 =$427.17 PMPM (N27 and N28, Appendix D5) *P3 =$478.84 PMPM (N39 and N40, Appendix D5)* *P4 =$481.24 PMPM (N50 and N51, Appendix D5)*		
Projected Administrative Costs **BY Calculated as 0.6% of total Medicaid Expenditures*		*0.5%*	*BY = $21.75 PMPM (Y12 and Y13, Appendix D5)* *P1 = $143.40 PMPM (AB15, Appendix D5)* *P2 = $114.00 PMPM (AB30, Appendix D5)* *P3 = $148.38 PMPM (AB42, Appendix D5)* *P4 = $91.15 PMPM (AB53, Appendix D5)*
Total *(Calculated as the sum of each period's PMPM X total period member months)*	*P1 = $600,975.81* *P2 = $1,160,194.96* *P3 = $1,514,576.14* *P4 = $1,737,742.69* *P1-P4 Total = $5,014,876.84*		*P1 = $275,041.20* *P2 = $309,738* *P3 = $469,474.32* *P4 = $329,233.80* *P1-P4 Total =$1,383,487.32*

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

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

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

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
Respite	*P1 = $313.33 PMPM (N12 and N13, Appendix D5)* *P2 =$427.17 PMPM (N27 and N28, Appendix D5)* *P3 =$478.84 PMPM (N39 and N40, Appendix D5)* *P4 =$481.24 PMPM (N50 and N51, Appendix D5)*	*0.5% per year (to match the current state plan service trend)*	*P1 = $162.38 PMPM (X15, Appendix D5)* *P2 = $163.19 PMPM (X30, Appendix D5)* *P3 = $164.01 PMPM (X42, Appendix D5)* *P4 = $164.83 PMPM (X53, Appendix D5)*
Total (Calculated as the sum of each period's PMPM X total period member months)	*P1 = $600,975.81* *P2 = $1,160,194.96* *P3 = $1,514,576.14* *P4 = $1,737,742.69* *P1-P4 Total = $5,014,876.84*		*P1 = $311,444.84* *P2 = $443,387.23* *P3 = $518,927.64* *P4 = $595,365.96* *P1-P4 Total =$1,869,125.67*

**** Note:** ***The State assures CMS that while the same calculated annual savings are reflected in both the table below and the (b)(3) service costs table, the total projected reductions are not duplicative, but simply an aggregate savings calculated sufficient in amount to offset both the administrative expense and the (b)(3) service costs.***

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

state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations: <u>They have not been included in the cost calculations and are assumed to be part of the auto-enrolled population.</u>

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

Basis and Method:

1._X__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.__**X**_Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1._**X**__[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.

If the CONTRACTOR meets the outcome performance measurement goals specified by the State, the PMPM for every youth enrolled with the CONTRACTOR will be increased by one half of one percent (0.5%) not to exceed a total of one hundred five percent (105%) of the contracted base PMPM.

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

The increased capitated payment will be paid as part of the per member, per month capitated payment based on qualified claims submitted to the Medicaid Management Information System (MMIS) as specified in the base contract and any subsequent amendments. Incentive payments will be based on contract year one (1) performance data (September 1, 2015 through June 30, 2016). Contract year one (1) performance data will be used to establish base line Contractor benchmark measurements and subsequent performance incentives and will be assessed based on the Contractor's performance as compared to the calculated benchmarks. This increased PMPM will continue until the next credit reporting period. The adjusted PMPM cannot exceed a total of one hundred five percent (105%) of the contracted base PMPM.

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.

The identified incentive payments will be paid as part of the PMPM based on claim submitted to the MMIS. System edits are in place to ensure that the total PMPM payment does not exceed one hundred five percent (105%) of the contracted base PMPM.

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.

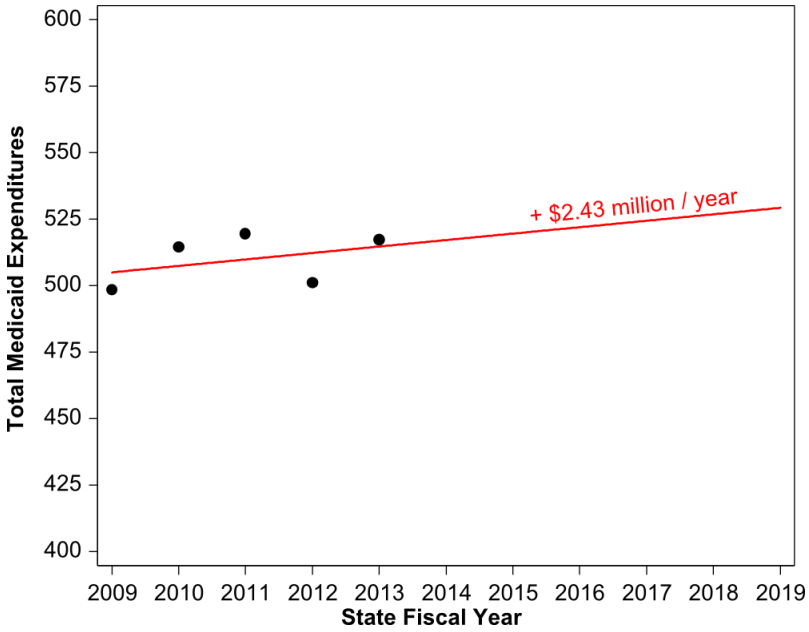
The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

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._X__[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: __0.5%_____. Please document how that trend was calculated:

A linear regression model was used trending Medicaid expenditures from SFY 2009 – 2013. The result was an annual increase of $2.4265 million per year. This dollar amount as a percentage of the 2013 BY expenditures calculates to be 0.5%. This state plan trend rate was developed based on global Medicaid expenditures prior to the approval of Targeted Case Management for Children with SED. Therefore, the calculated state plan trend rate is mutually exclusive of programmatic/policy/pricing changes.



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

i. _X__ State historical cost increases. Please indicate the years on which the rates are based: base years___*SFY2009-2013*_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The State of Wyoming used a simple linear regression model to calculate an annual service expenditure trend rate of 0.5%. The State's cost increase calculation was developed based only on historic program costs. No additional adjustments were made in

consideration of 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. _X_ **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._X__An adjustment was necessary. The adjustment(s) is(are) 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.____**X____**The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment __*37.1614 % or $1,361.44 PMPM_for MEG1, and 74.8665% or $1,361.44 PMPM for MEG2.*

Actuarial analyses performed on the current section1915(c) population resulted in a projected cost of $680.72 PMPM for each of the two additional provider roles (family support partner and youth support partner) for which service delivery costs did not exist in SFY2013 data. Targeted case management services delivered through a HFWA model was added to state plan effective March 1, 2014. The State used service costs for the family care coordinator from the 1915 (c) Children's Mental Health Waiver in its base year data as the projected allocation for this service under the new PAHP program. To this, $680.72 PMPM was added to that base for each the Family Support Partner and Youth Support Partner when establishing P1 aggregate cost projections.

The State provided national rate information to its actuary for services provided in other states for the same provider types under the same delivery model. The actuary used this rate information and the Youth and Family Training and Support utilization history from the 1915 (c) Children's Mental Health Waiver to develop the estimated PMPM for each of these two roles. By adding the costs for Family Support Partners and Youth Support Partners to the SFY2013 base (includes Family Care Coordinators from SFY2013 data) as an evidence-based best practice, this adjustment adds a total of $1,361.44 PMPM to the BY for both MEGs.

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.___ **X___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**._X__**An administrative adjustment was made.

i**._X__** 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.____**X**___Other (please describe):

Administrative cost adjustments were made based on the following activities. Corresponding % changes are located in Appendix D5, Column Z, Rows 13,28,40, and 51.

Additional Administration Expense	**Savings projected in State Plan Services**	**Amount projected to be spent in Prospective Period**
PAHP Program Implementation	*P1 = $313.33 PMPM (N12 and N13, Appendix D5)* *P2 =$427.17 PMPM (N27 and N28, Appendix D5)* *P3 =$478.84 PMPM (N39 and N40, Appendix D5)* *P4 =$481.24 PMPM (N50 and N51, Appendix D5)*	
Waiver Manager Position		*P1 = $33,333.33 (prorated for September 1, 2015 effective date)* *P2 = $100,000* *P3 = $100,000* *P4 = $100,000*
MMIS/EMWS Customization		*P1 = $200,000* *P2 = $0* *P3 = $0* *P4 = $0*
Actuary Expenses		*P1 = $50,000* *P2 = $50,000* *P3 = $50,000* *P4 = $50,000*
MMIS Re-procurement		*P1 = $0* *P2 = $100,667* *P3 = $100,667* *P4 = $100,667*
Independent Third-Party Program Review and Analysis		*P1 = $0* *P2 = $0* *P3 = $150,000* *P4 = $0*

Total (Calculated as the sum of each period's PMPM X total period member months)	*P1 = $600,975.81* *P2 = $1,160,194.96* *P3 = $1,514,576.14* *P4 = $1,737,742.69* ***P1-P4 Total = ($5,014,876.84 – total cost projected for (b)(3) service costs, $2,173,223.82) = $2,841,653.02***	*P1 = $233,333.33, addition of $121.65 PMPM from BY to* ***$143.40 PMPM*** *P2 = $250,667, addition of $92.26 PMPM from BY to a total of* ***$114.00 PMPM,*** *decrease of $29.40 PMPM (-20.505%) from P1* *P3 = $400,667, addition of $126.63 PMPM from BY to a total of* ***$148.38 PMPM,*** *increase of $34.38 PMPM (30.157%) from P2* *P4 = $250,667, addition of $69.40 PMPM from BY to a total of* ***$91.15 PMPM,*** *decrease of $57.23 (-38.57%) from P3* ***P1-P4 Total = $1,383,487.32 (prorated to account for a 10 month P1)***

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.

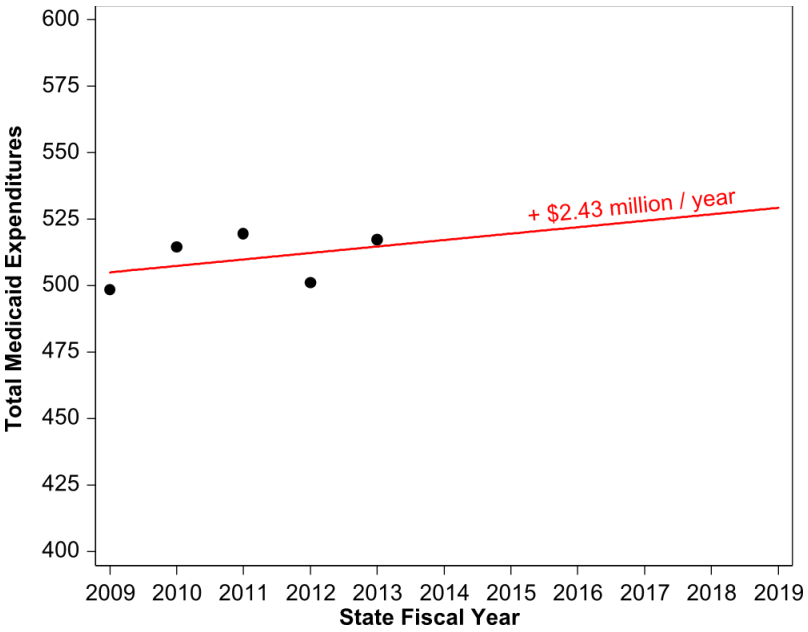
B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* 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._X__[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: __0.5%_____. Please provide documentation.

A linear regression model was used trending Medicaid expenditures from SFY 2009 – 2013. The result was an annual increase of $2.4265 million per year. This dollar amount as a percentage of the 2013 BY expenditures calculates to be 0.5%. This state plan trend rate was developed based on global Medicaid expenditures prior to the approval of Targeted Case Management for Children with SED. Therefore, the calculated state plan trend rate is mutually exclusive of programmatic/policy/pricing changes.



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._X_ Other (please describe): *Not applicable. In Wyoming's FFS methodology, GME has been excluded from rate development and thereby excluded from the base year data.*

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._X__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 chosen not to make an adjustment because the same copayments are collected in managed care and FFS.

4._X_ Other (please describe): *The State has made no adjustment for co-payments. The program is targeting/servicing children not eligible for copayments. Therefore, no copayments will be collected for services rendered through the waiver.*

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._X__No adjustment was necessary – *As TPL is not applicable to this program/service.*

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.__X_The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***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.__X_ 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.___ **X___**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.*___ **X___**Other (please describe): *FQHC/RHC services are not a component of the waiver program. Therefore, services provided as these sites will not be built in to the capitated rates.*

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.

*****This provision is not application to the State's program. Services included in the waiver are new state plan services and not previously or currently reimbursed via a FFS option.***

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

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

n. **Incomplete Data Adjustment (DOS within DOP only)** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is

usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

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

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

3.___ Other (please describe):

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

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

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

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

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

1. _X__No adjustment was made.

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

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

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

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

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

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

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

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

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase

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

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. ____ **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.___ An adjustment was necessary and is listed and described below:

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

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

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

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

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

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

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

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

D.____Other (please describe):

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

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

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

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

D.____Other (please describe):

vi.__ Other (please describe):

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

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

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

D.____Other (please describe):

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

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

2.___ An administrative adjustment was made.

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

ii.___ Cost increases were accounted for.

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

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

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

D.____Other (please describe):

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

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

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

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

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

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

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

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

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

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

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

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

3. Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated. *Basis and Method:*

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

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not

prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.
2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

Due to the void in cost experience under a fee-for-service environment for targeted case management services delivered through HFWA, the State is using and applying the service utilization experience from the current 1915 (c) Children's Mental Health Waiver (CMHW) youth for development of all cost assumptions and projections. In comparing the two populations of youth, similarities exist supporting the State's request for consideration of the proxy:

I. Clinical qualifications – both the CMHW and PAHP youth are required to meet standard clinical eligibility guidelines; 1) Youth ages 6-20 must have a minimum Child and Adolescent Service Intensity Instrument (CASII) composite score of twenty (20), and youth ages 4 & 5 must have an Early Childhood Service Intensity Instrument (ECSII) score of eighteen (18) to thirty (30) OR the appropriate social and emotional assessment information provided to illustrate level of service needs; and 2) Must have a DSM Axis 1 or ICD diagnosis that meets the State's diagnostic criteria.

II. Ages served – both the CMHW and PAHP serve youth between the ages of 4 and 21.

III. Providers – Most of the current CMHW providers will also be providers under contract with the PAHP.

IV. Services – both the PAHP and CMHW focus on family care coordination as the central service of support available to enrolled youth and families. Both programs utilize HFWA principles and practices for delivering services. Under the 2013 CMHW, Youth and Family Training and Support Services paralleled services that will now be Family and Youth Peer Support in the PAHP. Additional services are currently being built out under the PAHP to fully operationalize all three prongs (provider types and service delivery model components) of HFWA.

V. Geography – The CMHW is currently available state wide, but enrollment and participation is limited to seventy-five (75) youth at any given time. The PAHP will also be statewide.

The State has also worked to identify any program differences that may lead to unintended variation in service utilization between the two groups. While some program components between the 2013 CMHW and the PAHP are different, the State has not identified any difference projected to result in service utilization variation between program groups. Differences identified include:

I. Financial Eligibility – the current financial eligibility and income requirements between the two programs are different. The PAHP will service youth who are eligible for Medicaid through an existing state plan eligibility group and the CMHW will serve youth up to 300% of the SSI income level without regard to parent/guardian income. The State has no evidence to support a difference in financial eligibility criteria leading to service utilization variances between youth.

II. Providers – while most CMHW providers also work under contract with the PAHP, the waiver does have a few independent providers not affiliated. The State has no evidence to support a difference in agency vs. independent provider choice leading to service utilization variances between youth.

The State anticipates enrollment to flatten at approximately 40% of those youth identified to meet initial program targeting criteria (600 in SFY2013). The demographic and transient nature of Wyoming's Medicaid population in general has made it difficult to locate and contact youth/families referred to the existing pilot program. Once initial contact is made for program participation, confirmation of clinical and financial eligibility criteria has not exceeded 40% under the current pilot. The State anticipates this same trend to continue.

Definitions:

MEG1 – State Plan Enrolled Youth: *This group includes all Medicaid State Plan eligible youth based on an analysis of prior state plan service utilization against program criteria. The benefit package for this MEG includes targeted case management (TCM) delivered through a high fidelity wraparound model (family care coordination, family support services, and youth support services) and respite.*

*Base year member months = (600 eligible youth **X** 40% projected enrollment rate = 240 youth) **X** 12 projected member months per youth =* ***2,880 SFY2013 base member months***

MEG2 – 1915 (c) Enrolled Youth: *This group includes all youth qualifying for services through Wyoming's existing 1915 (c) Children's Mental Health Waiver. The benefit package for this MEG includes targeted case management (TCM) delivered through a high fidelity wraparound model (family care coordination, family support services, and youth support services), youth and family training and support services and respite.*

The base year member month for MEG2 - 1915 (c) Enrolled Youth is 782. This metric comes directly from SFY2013 enrollment data.

September 1, 2015, the new PAHP contractor will be assuming enrollment of all current program participants (under the current contractor) as well as all youth enrolled in Wyoming's section 1915 (c) Children's Mental Health Waiver. The state funded pilot program has been operational in only the seven southeast counties of the State. The initial program population, to include both Medicaid State Plan and section 1915 (c) waiver youth is projected to be 175 youth in P1, Q1 (100 youth enrolled through Medicaid State Plan and 75 1915 (c) waiver youth).

MEG 1 P1, Q1 = 100: 100 youth based on 1 month in Q1 with a September 1, 2015 implementation date. This projected reflects current enrollment rates moving in to the September 1 assumption of service delivery by the PAHP.

MEG 2 P1, Q1 = 75: 75 youth max waiver capacity based on 1 month in Q1 with a September 1, 2015 implementation date.

Moving forward, for the MEG1 group the average experienced enrollment rate has been 7-9 youth/ month. The State has added 9 youth per month (or 28 per quarter) to the total member months calculated if Q1 had been a 3 months (increase of 228% P1, Q2; 8.5% P1, Q3; 7.9% P1, Q4; 7.3% P2, Q1; 6.8% P2, Q2; 6.4% P2, Q3; 6.0% P2, Q4; 5.6% P3, Q1; 5.3%

P3, Q2; 5.1% P3, Q3; 4.8% P3, Q; 4.6% P4, Q1, 4.4% P4, Q2; 4.3% P4, Q3 each quarter) to the projected member months up to a maximum of 240 youth for MEG 1 (40% of the 600 eligible youth) identified in the base year as meeting the program's current initial targeting criteria. In Appendix D1, only the MEG1 group is shown to increase in enrollment, as it's assumed the MEG2 will remain constant at the maximum waiver capacity (75 youth).

The State is projecting an enrollment rate no more than 40% of potential State Plan youth due to the demographic and transient characteristics of the Medicaid population in general. The State anticipates that some youth will have relocated out of state, the PAHP will be unable to locate some for additional medical eligibility assessments, or the youth will not meet the medical eligibility criteria as established in this waiver. Year four enrollment projections are estimated to become relatively flat in Q4 due to the short term targeted intervention nature of the program. The program is not a permanent, long term service solution. As youth no longer meet medical eligibility criteria for participation, they will be dis-enrolled while other newly identified youth are enrolled.

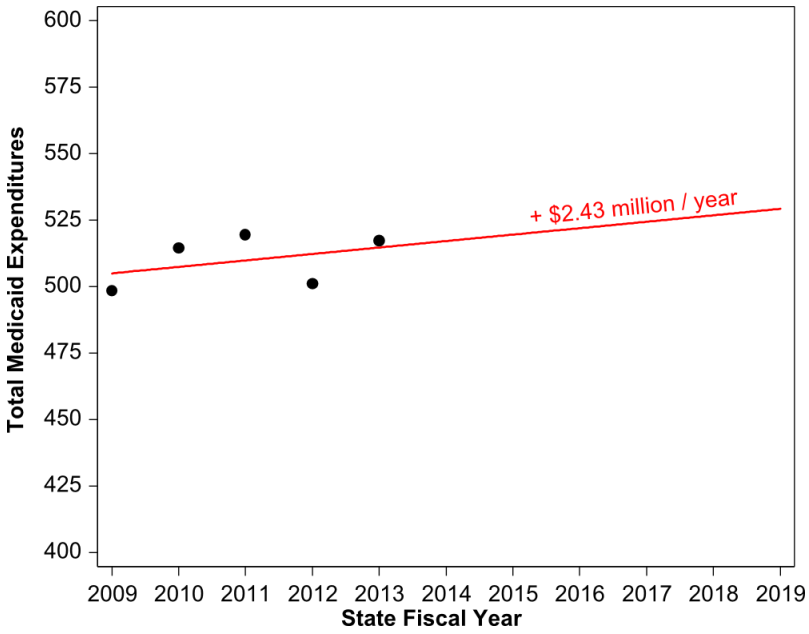
It is the State's expectation that with the marketing and promotion of the delivery model to the targeted population state-wide, overall acceptance of and participation in the program will increase the total member months by the addition of 7-9 youth/ month to the MEG1 population, to a projected maximum of 40% enrollment of State Plan youth (240 X 12 months) and 75 waiver youth (75 X 12 months) for a total of 3,780 member months per year when both programs are functioning at the projected capacity.

The member month trend projected for MEG2 is consistent with current approved waiver capacity. At maximum capacity, the waiver can only serve 75 youth at any one time, with the exception of P1 which has been prorated to account for the 1 month of program implementation. For SFY 2013, there were 782 member months. This trend remains consistent across the four program years, but is slightly higher than base year data. The waiver, in SFY2013 was not operating a full capacity due to budgetary restrictions. However, with the new PAHP contractor on board and program realignment with the PAHP, the State anticipates maximizing waiver utilization and serving 75 youth at a time throughout the year. The P1 – P4 anticipated member months across all four program years is 225 (75 youth multiplied by 12 months/ 4 quarters) with the exception of P1, Q1 given the 1 month quarter versus a traditional 3 month quarter.

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**:

State Plan Trend Adjustment*: A linear regression model was used trending Medicaid expenditures from SFY 2009 – 2013. The result was an annual increase of $2.4265 million per year. This dollar amount as a percentage of the 2013 BY expenditures calculates to be 0.5%. This state plan trend rate was developed based on global Medicaid expenditures prior to the approval of Targeted Case Management for Children with SED. Therefore, the calculated state plan trend rate is mutually exclusive of programmatic/policy/pricing changes.*



State Plan Services Programmatic/Policy/Pricing Change Adjustment:
Actuarial analyses performed on the current section1915(c) population resulted in a projected cost of $680.72 PMPM for each of the two additional provider roles (family support partner and youth support partner) for which service delivery costs did not exist in SFY2013 data. Targeted case management services delivered through a HFWA model was added to state plan effective March 1, 2014. The State used service costs for the family care coordinator from the 1915 (c) Children's Mental Health Waiver in its base year data as the projected allocation for this service under the new PAHP program. To this, $680.72 PMPM was added to that base for each the Family Support Partner and Youth Support Partner when establishing P1 aggregate cost projections.

The State provided national rate information to its actuary for services provided in other states for the same provider types under the same delivery model. The actuary used this rate information and the Youth and Family Training and Support utilization history from the 1915 (c) Children's Mental Health Waiver to develop the estimated PMPM for each of these two roles. By adding the costs for Family Support Partners and Youth Support Partners to the SFY2013 base (includes Family Care Coordinators from SFY2013 data)

as an evidence-based best practice, this adjustment adds a total of $1,361.44 PMPM to the BY for both MEGs.

1915 (b)(3) Service Trend: *This rate was calculated to mirror the state plan service trend due to lack of historical data. A linear regression model was used trending Medicaid expenditures from SFY 2009 – 2013. The result was an annual increase of $2.4265 million per year. This dollar amount as a percentage of the 2013 BY expenditures calculates to be 0.5%. This state plan trend rate was developed based on global Medicaid expenditures prior to the approval of Targeted Case Management for Children with SED. Therefore, the calculated state plan trend rate is mutually exclusive of programmatic/policy/pricing changes.*

Administrative Cost Adjustments*: See table in Section D:*

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
PAHP Program Implementation	*P1 = $313.33.00 PMPM (N12 and N13, Appendix D5)* *P2 =$427.17 PMPM (N27 and N28, Appendix D5)* *P3 =$478.84 PMPM (N39 and N40, Appendix D5)* *P4 =$481.24 PMPM (N50 and N51, Appendix D5)*		
Projected Administrative Costs **BY Calculated as 0.6% of total Medicaid Expenditures*		*0.5%*	*BY = $21.75 PMPM* *P1 = $143.40 PMPM* *P2 = $114.00 PMPM* *P3 = $148.38 PMPM* *P4 = $91.15 PMPM*
Total *(Calculated as the sum of each period's PMPM X total period member months)*	*P1 = $600,975.81* *P2 = $1,160,194.96* *P3 = $1,514,576.14* *P4 = $1,737,742.69* *P1-P4 Total = $5,014,876.84*		*BY = $79,660* *P1 = $275,041.20* *P2 = $309,738* *P3 = $469,474.32* *P4 = $329,233.80* *P1-P4 total = $1,383,487.32*

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.