TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

MEMORANDUM

TO: Office of the Governor
Legislative Budget Board
Senate Committee on Health and Human Services
House Committee on Human Services
House Committee on Public Health

FROM: External Relations Division, Health and Human Services Commission

DATE: March 25, 2008

SUBJECT: Application for renewal of the STAR Program

Pursuant to the 2008-2009 General Appropriations Act (Article II, Health and Human Services Commission, Rider 31(a), H.B. 1, 80th Legislature, Regular Session, 2007), this memo serves as notification that the Health and Human Services Commission (HHSC) is submitting to the Centers for Medicare and Medicaid Services (CMS) an application for renewal of the State of Texas Access Reform (STAR) Program under the authority of §1915(b) of the Social Security Act.

The current 1915(b) waiver is approved from July 1, 2006, to June 30, 2008. The principle objective of the STAR program is early intervention and improved access to quality care, resulting in improved health outcomes for Medicaid recipients who receive cash assistance (Temporary Assistance for Needy Families [TANF]), pregnant women, and recipients with limited income; with a special focus on prenatal and well-child care. Clients enrolled in STAR receive all of the traditional Medicaid benefits plus the additional STAR benefits, including annual check-ups for adults, unlimited prescriptions for adults, no limit on necessary hospital days, and health education classes.

HHSC is requesting the waiver application be approved for a two-year period beginning July 1, 2008, and ending June 30, 2010. Cost savings from this waiver application are expected for the state for each year in the two-year period covering 2008 through 2010. The estimated cost savings are as follows:

- Total cost savings of approximately $545 million.
    - Approximately $324 million in federal funds.

  - Approximately $221 million in state general revenue.
- First year savings of approximately $257 million.
  - Approximately $153 million in federal funds.
  - Approximately $104 million in state general revenue.
- Second year savings of approximately $288 million.
  - Approximately $171 million in federal funds.
  - Approximately $117 million in state general revenue.

Should you require additional information, please contact Kay Ghahremani, Deputy Director for Medicaid and CHIP Policy Development, by telephone at (512) 491-1339, or by e-mail at Kay.Ghahremani@hhsc.state.tx.us.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

March 12, 2008

Mr. Bill Brooks
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

Mr. Brooks:

The State of Texas respectfully submits for your review and approval the enclosed §1915(b) renewal application for the State of Texas Access Reform (STAR) program. The approval of this application will allow the state to continue with the Medicaid managed care consolidated waiver. The state requests a two-year approval of this waiver, effective July 1, 2008, through June 30, 2010.

Please let me know if you have any questions or need additional information. Betsy Johnson, Policy Analyst in the Medicaid and CHIP Division, serves as the lead staff on this matter and can be reached at (512) 491-1199 or by e-mail at betsy.johnson@hhsc.state.tx.us.

Sincerely,

Chris Traylor
State Medicaid Director

CT:BJ:csh

cc: Linda Territo, CMS
Jean Sheil, CMS

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

MMA amendment version
July 01, 2008 through June 30, 2010

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Instructions – see Attachment 1

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

Facesheet

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

The **State** of _Texas_ 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 State of Texas Access Reform (STAR). (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:
___ initial request for new waiver. All sections are filled.
___ amendment request for existing waiver, which modifies Section/Part ____
  __ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
  __ Document is replaced in full, with changes highlighted
_X__ renewal request
  ___ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
  _X_ The State has used this waiver format for its previous waiver period.
Sections
  C and D are filled out.
    Section A is ___ replaced in full
      ___ carried over from previous waiver period. The State:
        ___ assures there are no changes in the Program Description from the previous waiver period.
        ___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

    Section B is ___ replaced in full
      ___ carried over from previous waiver period. The State:
        ___ assures there are no changes in the Monitoring Plan from the previous waiver period.
        ___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective **July 1, 2008**, and ending **June 30, 2010**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Betsy Johnson and can be reached by telephone at (512) 491-1199 or fax at (512) 491-1953, or e-mail at betsy.johnson@hhsc.state.tx.us. (Please list for each program)

Section A: Program Description

Part I: Program Overview

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

On January 18, 2008, HHSC sent letters notifying the Federally recognized Tribes of their opportunity to comment on the waiver proposal.

Program History
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

In response to rising health care costs and a national focus on examining new methods for providing both quality health care and cost savings, the Texas legislature passed House Bill 7 in 1991, establishing the Medicaid managed care pilot in Travis County and the tri-county area of Jefferson, Chambers and Galveston counties. Since 1993, the State received approval from the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), to implement 1915(b) waivers in eight service areas throughout the State. In an effort to reduce duplication and streamline the waiver application process, in the Fall of 2000, the State submitted a waiver application to combine the eight 1915(b) waivers into one consolidated 1915(b) waiver.
House Bill (HB) 2292, Section 2.29 78th Legislature, Regular Session, 2003, required the delivery of acute care Medicaid Services through the most cost-effective model of managed care. Upon completion and analysis of an independent cost effectiveness study conducted pursuant to HB 2292, HHSC released in February 2004 a proposed framework for expanding Medicaid managed care in Texas that included a geographical expansion of the STAR Managed Care Organization (MCO) program and changes to the Primary Care Case Management (PCCM) program in new and existing STAR MCO Service Areas.

During March 2004, HHSC accepted public comment on the proposed framework and conducted 26 public hearings around the state. Also during March 2004, HHSC released for comment a draft Request for Proposals (RFP) to procure MCO services for Medicaid and the Children's Health Insurance Program (CHIP). In the RFP, HHSC incorporated an enhanced value-based purchasing approach that includes a new approach to contract management, as well as specific performance incentives for the contracted MCOs. The comments received by HHSC were reviewed, and the final Joint Medicaid/CHIP HMO RFP was released on July 2, 2004. The RFP included expanding the STAR MCO program into a newly created Nueces Service Area, deleting two counties (Hudspeth and Culberson) from the current MCO service area in El Paso, and deleting one county (Blanco) from the Travis Service Area. (These counties were moved into PCCM and

now fall under the PCCM State Plan Amendment.) MCO proposals were due to HHSC on September 9, 2004. HHSC made tentative contract awards on July 7, 2005, and finalized contracts with an effective date of November 15, 2005.

HHSC withdrew PCCM from STAR service areas through a phased out approach. Mandatory members phased out over a three-month period. Voluntary members phased out over a four-month period. As of September 1, 2006, PCCM (Texas Health Network or THN) is no longer a choice for new enrollees. Existing THN members were notified of the State's discontinuance of PCCM in their service area. The state provided THN members with information about the HMO plan choices in the service area and instructions on deadlines to choose another health plan. Mandatory members were not defaulted until the December 2006, enrollment cut-off (which occurred around November 15, 2006). If the members did not make a plan choice by the specified time, they were defaulted into an HMO effective December 1, 2006. Voluntary members were not defaulted into an HMO unless they did not choose an HMO by the January 2007, cut-off (which occurred around December 15, 2006). If they did not make a plan choice by the specified time, they were defaulted into an HMO effective January 1, 2007.

A. Statutory Authority

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

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

b. _X__**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

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

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

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

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

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

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

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

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

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

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

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

   e. ___ **Fee-for-service (FFS) selective contracting:** 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.**

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

___ 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.

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

_X__ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
___ Other: (please describe)

3. **Rural Exception.**

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

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

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

D. Geographic Areas Served by the Waiver

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

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

_X__ **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)
Bexar Service Area: Bexar, Atascosa, Comal, Guadalupe, Kendall, Medina, and Wilson Counties	MCO	AETNA Community First Health Plans Superior HealthPlan
Dallas Service Area: Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties	MCO	Amerigroup Texas, Inc. Parkland Community Health Plan Unicare Health Plans of Texas, Inc.
El Paso Service Area: El Paso County	MCO	El Paso First Health Plan Superior HealthPlan
Harris Service Area: Harris, Brazoria, Fort Bend, Galveston, Montgomery, and Waller Counties	MCO	Amerigroup Texas, Inc. Community Health Choice Texas Children's Health Plan Molina Healthcare of Texas, Inc. United
Lubbock Service Area: Lubbock, Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lynn, and Terry Counties	MCO	FirstCare Superior HealthPlan
Nueces Service Area Nueces, Aransas, Bee, Calhoun, Jim Wells, Kleberg, Refugio, San Patricio, and Victoria Counties	MCO	Amerigroup Texas, Inc. Driscoll Children's Health Plan Superior HealthPlan

Tarrant Service Area: Tarrant, Denton, Hood, Johnson, Parker, and Wise Counties	MCO	AETNA Amerigroup Texas, Inc. Cook Children's Health Plan
Travis Service Area: Travis, Bastrop, Burnet, Caldwell, Hays, Lee, and Williamson Counties	MCO	Amerigroup Texas, Inc. Superior HealthPlan

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.

___ Mandatory enrollment
_X__ 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.

___ Mandatory enrollment
_X__ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

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

___ **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

___ 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).

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

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

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

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

___ Other (Please define):

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).

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

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

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

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

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

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

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

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:

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

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

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

___ Other (please explain):

___ Family planning services are not included under the waiver.

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.

__X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a

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

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

5. **EPSDT Requirements.**

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

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

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

The waiver includes three 1915(b)(3) services:

- **Unlimited prescriptions for adults ages 21 and older (this population has a three prescription per month limit in fee-for-service). Prescription drug services are not included in the capitation, but are provided through any participating Medicaid pharmacy throughout the state and reimbursed through fee-for-service.**
- **Annual adult well check for adults 21 years of age and over. This service is provided by the MCOs' PCPs, and is included in the capitation rate paid to MCOs. This benefit is available in all Service Areas of the state.**
- **Elimination of the 30-day spell-of-illness limitation that applies in fee-for-service. All STAR members are eligible for this benefit. The first 30 days' costs for this benefit are included in the capitation paid to MCOs, and costs for services after 30 days are paid out of cost savings. This benefit is available in all Service Areas in the state.**

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

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

In addition to emergency, family planning, **vision care** and obstetric or gynecological services services, members may self-refer to outpatient behavioral health services and to services through the Early Childhood Intervention (ECI) program.

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.

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

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.

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

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

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

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

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

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

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

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

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

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

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

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

g. ___ **Other capacity standards** (please describe):

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

C. Coordination and Continuity of Care Standards

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

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

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

_*__ 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. *"**In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

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

The following items are required.

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

b. X___ **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.

HHSC implemented a screening tool used by the Enrollment Broker during the enrollment process to identify members that may have special health care needs. MCOs are responsible for following up by contacting these members to assess for special health care needs.

c. _X__**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.

MCOs must contact members screened by the Enrollment Broker as having special health care needs to determine whether they meet the MCO's assessment criteria, and to determine whether the member requires special services. MCOs must provide information to the Enrollment Broker that identified members who the MCO has assessed as having special health care needs, including any members pre-screened by the Enrollment Broker and confirmed by the MCO as having special health care needs.

d. __X_**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._X_ 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._X_ In accord with any applicable State quality assurance and utilization review standards.

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

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

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

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

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

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

1. **<u>Assurances for MCO or PIHP programs</u>**.

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

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

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

_X__ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on _August 3, 2005
.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	University of Florida -	Annual focused	Annual quality of	Assist state with

	Institute for Child Health Policy	studies and ad hoc queries identified by the State.	care, access to care, and financial performance measures for all MCOs	identification of new performance measures for MCOs
PIHP	NA	NA	NA	NA

2. **Assurances For PAHP program.**

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

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

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

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

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

A. ___ Initial credentialing

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

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

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

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

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

7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

_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.

__*_ 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. ***In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

___ 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.

Radio, TV, Billboard, Bus Signs, Bench Displays, Newspaper, Decals and Banners.

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.

Direct mail marketing is prohibited; however, MCOs are permitted to conduct direct marketing during HHSC-approved Enrollment Events.

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.

MCOs are allowed to offer nominal gifts valued at no more than $10.00 as long as the gifts are offered whether or not the potential member enrolls in the health plan.

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):

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 _10__ 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.

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

___ 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 _10__ 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 Enrollment Broker uses the AT&T Language Line Services for any language for which it does not have in-house capability. (A description of AT&T Language Line Services can be found at http://www.languageline.com/.)

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

The parent/caretaker of a child newly certified for Medicaid is required to attend a health care orientation. This orientation includes an explanation of managed care. Mandatory potential enrollees are sent or given an enrollment packet that covers these same topics. Voluntary potential enrollees receive an informational letter that explains how managed care works. These voluntary enrollees may ask for an enrollment packet. Potential enrollees (mandatory or voluntary) who call the STAR helpline are given education about managed care. MCOs provide new enrollees with information about how to access the managed care system and about their rights and responsibilities.

As of January 2004, one consumer guide is mailed to each Medicaid household upon Medicaid certification.. The consumer guide includes an explanation of managed care.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State

_X_ contractor (please specify) the Enrollment Broker, who is **MAXIMUS**.

___ 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) __X_ State contractor (please specify):**MAXIMUS**
(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)

__*_ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

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

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

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

The Enrollment Broker's regional offices have outreach workers housed in facilities such as the Department of Aging and Disability services (DADS) and other local organizations and agencies to provide education and outreach through enrollment events and other activities such as group presentations, one-on-one counseling (face-to-face in the region), and health fairs.

The Enrollment Broker works very closely with communities to reach special needs populations. Agreements and subcontracts are made with the

Community Based organizations (CBOs) to assist the Enrollment Broker in educating and enrolling recipients. In each service area, the Enrollment Broker participates in community groups, coalitions, and committees that work directly with the special needs populations.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

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

_X__ 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: **__MAXIMUS**

Please list the functions that the contractor will perform:

_X__ choice counseling

_X__ enrollment

___ other (please describe):

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

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

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

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

_X__ 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. _X__Potential enrollees will have **at least 30 days**/month(s) to choose a plan. **Pregnant recipients are given up to 16 days to choose a plan**.

ii. _X__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.

Please see Attachment D for detailed description of the default methodology. (The auto-assignment process considers an enrollee's history with a primary care provider in making an assignment. This consideration is not limited to persons with special health care needs. The process does not consider a physician's capability to service particular health care needs.)

___ The State **automatically enrolls** beneficiaries

- ___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- ___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- ___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: ____________

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

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

_X__ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of **6** months or less.

d. **Disenrollment:**

_X__ 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._X__ **Enrollee submits request to State. Enrollee may request transfer to another MCO in the service area through the Enrollment Broker.**

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):

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

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

i._X__ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
HHSC's contract with the MCO spells out the limited reasons for which an MCO may make such a request. The reasons a member may be disenrolled from a plan are: 1) if a member misuses or loans the member's membership card to another person to obtain services; 2) if a member is disruptive, unruly, threatening, or uncooperative to the extent that the member's membership seriously impairs the MCOs ability to provide services to the member, or to obtain providers, and the member's behavior is not caused by a physical or behavioral condition; or 3) if a member steadfastly refuses to comply with managed care, such as repeated

emergency room use combined with refusal to allow the PCP to treat the underlying medical condition.

The MCO cannot request a disenrollment based on adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition. In addition, the MCO may not request a disenrollment of an individual based on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion.

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

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

HHSC will either exempt the member from participation in the STAR program or will require the MCO to continue serving the member, with suggestions for alleviating the issue that caused the MCO request. In addition, the State may work with other MCOs in the service area to accept the member into their plan rather than disenrolling them completely from managed care.

D. Enrollee rights.

1. **<u>Assurances</u>.**

_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.

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

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

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

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

_*__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

3. **<u>Details for MCO or PIHP programs</u>**.

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.

__X_ 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**

_X__ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **_30__** days (between 20 and 90).

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

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.

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

___ The grievance procedures is operated by:

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

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

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

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

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

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

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

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

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

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

_X__ 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. * **In accordance with CMS requirements, HHSC will submit in Summer 2008 all contract amendments that extend the term beyond the current expiration date of August 31, 2008.**

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

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

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

II. Details of Monitoring Activities

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

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

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

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

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

HHSC does not use accreditation for non-duplication because HHSC has its own standards and monitoring processes. - HHSC does not require national accreditation for an managed care organization (MCO) to enter into a Medicaid contract. In Texas, the Texas Department of Insurance (TDI) is the single state agency responsible for licensing health plans. TDI's licensing requirements and standards are more strict than those established by the national organizations, with the exception of NCQA's Quality Improvement program. On an annual basis, the EQRO reviews MCO accreditation status and provides feedback to HHSC. Should a MCO receive NCQA accreditation in the QI program, TDI and HHSC would presume compliance in order to meet state standards and deem that portion of the MCO accredited without further exam by TDI or HHSC. To date, no MCO has been so deemed and they continue to undergo full TDI exam to meet licensing standards. Additionally, HHSC Medicaid MCO contracts include reference to TDI standards and have developed other specific areas of performance and standards. MCO contract and performance compliance are monitored by HHSC and/or the EQRO.

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

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

HHSC does not require accreditation for participation because HHSC has its own standards and monitoring processes. Accreditation by these organizations is also expensive, and may be burdensome for the smaller community-based MCOs.

c. __X___ Consumer Self-Report data

_X__ CAHPS (please identify which one(s))

Percentage of good access to urgent care
Percentage of good access to specialist referral
Percentage of good access to routine care
Percentage of no delays for an approval
Percentage of no exam room wait greater than 15 minutes
Percentage of good access to special therapies
Percentage of good access to BH treatment or counseling
Percentage of smokers advised to quit

___ State-developed survey
___ Disenrollment survey
_X__ Consumer/beneficiary focus groups

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQRO, other contractor): **HHSC and EQRO**

Detailed description of activity: **The EQRO conducts telephone survey instruments and record reviews.**

Frequency of use: **quarterly and annually**

How it yields information about the area(s) being monitored: **Surveys and record reviews yield individual health plan results in a specific service delivery area. Analyses produce multivariant and descriptive statistics that enable comparisons to national and state standards to identify areas of improvement.**

d. ___X__ Data Analysis (non-claims)

___ Denials of referral requests
_X__ Disenrollment requests by enrollee
    _X__ From plan
    ___ From PCP within plan
_X__ Grievances and appeals data
_X__ PCP termination rates and reasons

_X__ Other (please describe) Requests from enrollees to disenroll from Medicaid Managed Care.

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQRO, other contractor); HHSC, Health Plan Operations Unit.

Detailed description of activity: **HHSC analyzes data from reports received from internal and external sources to evaluate performance, ensure contract compliance and determine trends.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Data will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems.**

e. _X____ Enrollee Hotlines operated by State

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) **state Medicaid Ombudsman**

Detailed description of activity **Ombudsman office provides information and education to clients, helps resolve complaints from clients, and makes referrals to appropriate entities (Enrollment Broker, local HHSC Eligibility Office, MCO, etc).**

Frequency of use: **Daily and Monthly**

How it yields information about the area(s) being monitored **Ombudsman Office provides monthly detailed reports of barriers and issues clients encounter.**

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, EQRO, and MCOs**

Detailed description of activity: **HHSC and/or MCOs propose topics for focus studies. EQRO reviews proposals and makes recommendations to HHSC and MCOs prior to conducting study. Post-study, EQRO analyzes findings and provides HHSC and MCOs, as appropriate, with report and recommendations. Data used for studies can be from encounter/claim data, surveys/questionnaires, etc**.

Frequency of use: **Annually**

How it yields information about the area(s) being monitored: **Specialized studies are selected to help identify impact to geographic, demographic, service delivery, medical benefits, financial arrangements and cost sharing, enrollment, care coordination, and/or cost sharing and case mix.**

g. __X___ Geographic mapping of provider network

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit**

Detailed description of activity: **HHSC will monitor GeoAccess maps/analysis to ensure that providers are available to members within a specified mileage radius.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems.**

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

HHSC has already submitted Independent Assessments for the two previous waiver periods, and has confirmed with CMS that it does not need to submit an Independent Assessment.

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC and EQRO**

Detailed description of activity: **Encounter and claims data along with supplemental data from client surveys are collected and analyzed, using various means, to identify disparities.**

Frequency of use: **Quarterly and Annually**

How it yields information about the area(s) being monitored: **Results are used to report demographic, geographic, household, financial, and other attributes of individual members and their families, including race and ethnicity for each program and health plan/service area covered.**

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit**

Detailed description of activity: **HHSC analyzes data from reports submitted by MCO and Enrollment Broker and Geo/Access maps/analysis to ensure that an adequate number of providers are available to members with open panels and within the specified mileage radius. HHSC will use the performance indicators to compile and update Performance Dashboards as part of the contract management and incentive approach in the new contract.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems**.

k. _X____ Ombudsman

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) **HHSC has an Ombudsman office that makes referrals to the Resolution Services Section. The Resolution Services Section was established under the Health Plan Operations Unit in 2004 to resolve member and provider complaints.**

Detailed description of activity: **Resolution Services researches complaints after a member or provider has exhausted the appeal process with the MCO.**

Frequency of use: **Daily**

How it yields information about the area(s) being monitored: **By tracking the types of complaints over time, HHSC can identify trends that may be occurring.**

l. ___X__ On-site review

Personnel responsible (e.g.) state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC and EQRO**

Detailed description of activity: **The EQRO conducts MCO Administrative Interviews using both written survey documents and on-site interviews and reviews. Survey and interviews cover the following:**

MCO Organizational Structure
Children's Programs
Care Coordination and Disease Management Programs
Utilization and Referral Management

Provider Network
Provider Reimbursement
Member/Enrollee Rights
Grievance Procedures
Health Information Management
Data Acquisition
New Enrollees
Delegation
Value Added Services

Frequency of use: **Annually**

How it yields information about the area(s) being monitored: **EQRO produces an annual report and matrix that identifies multi-level attributes within each category about a specific MCO, allowing the state to compare activities by MCO across the state.**

Additional On-Site Activities: Prior to operational implementation of new contracts, Health Plan Operations (HPO) financial staff will perform financial readiness reviews and a Readiness Review contractor will perform Operations/Systems readiness reviews. HPO financial staff will review annual statements, annual audited financial statements, Department of Insurance exam reports, and MCO liability insurance coverage to demonstrate MCOs' financial solvency, i.e., ability to met minimum net worth requirements throughout the contract period. Contractor will review organizational structure, Management Information Systems (MIS)designs, member and provider materials, provider networks, utilization management systems, claims processing systems, and polices and procedures to demonstrate MCOs' ability perform according to the contract terms.

An audit Contractor performs financial audits to ensure accuracy of annual Financial Statistical Reports (FSR) submitted by MCOs to HHSC. Establishing data integrity is critical to future rate development. Audits are scheduled to occur annually.

Contractor will conduct risk-basked MCO performance audits every other year to provide HHSC with an independent assessment of performance, to improve public accountability, and to facilitate decision-making regarding overseeing or initiating corrective action.

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit; EQRO**

Detailed description of activity: **HHSC will monitor key MCO performance indicators (HEDIS, CAHPS, provider network, and administrative composition measures) to compile and update MCO Performance Dashboards and Performance Improvement Goals as part of the contract management and incentive approach used in the MCO contracts. Additionally, the EQRO conducts the MCO Administrative interview and MCO QIP/QAPI reviews of MCO quality improvement methodologies and reports findings to the state.**

Frequency of use: **Quarterly and Annually**

How it yields information about the area(s) being monitored: **Data will demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems. EQRO makes independent observations and recommendations for areas of continuous improvement across programs and health plans.**

n. __X___ Performance measures [**Required** for MCO/PIHP]

Process Performance Measures

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC**

Detailed description of activity: **HHSC uses call center-related performance measures and complaint and appeal-related performance measures. MCOs are required to submit data related to performance measures to HHSC.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Health plan managers identify MCOs that are not meeting state standards and work with MCOs to improve performance**.

Health Status/Outcome Performance Measures

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC and EQRO**

Detailed description of activity: **EQRO conducts an independent assessment of State's disease management initiative(s), provides care coordination for chronic conditions and special health care needs, conducts focused studies, and provides ad hoc reports as needed by the state**.

Frequency of use: **Quarterly and Annually**

How it yields information about the area(s) being monitored: **EQRO's work provides data and recommendations to HHSC on MCO activities and**

performance, and member/enrollee health care needs and health management.

Access/availability of care performance measures

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit has responsibility but has delegated certain monitoring functions to MCO and EQRO.**

Detailed description of activity: **MCO monitors accessibility/availability of providers through spot checks, and the EQRO conducts CAHPS surveys**.

Frequency of use: **Annually**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems.**

Use of services/utilization

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, MCOs, and EQRO**

Detailed description of activity: **EQRO utilizes CAHPS, CSHCN Screener, MHMR, HEDIS, and other survey tools, as well as encounter and claims data analysis to provide reports to HHSC. MCOs maintain a system and procedures for identifying member service utilization.**

Frequency of use: **EQRO: annual reporting; MCOs: ongoing analysis**

How it yields information about the area(s) being monitored: **EQRO provides independent review of programs, service delivery areas, and health plan activities for HHSC. MCOs are required to maintain a system that identifies health delivery and utilization to provide the covered services to meet the preventive, primary acute, and specialty health care needs appropriate for treatment of the enrollee/member's condition.**

Health plan stability/financial/cost of care performance measures

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) **HHSC , Health Plan Operations**

Detailed description of activity: **HPO financial staff monitor financial/cost of care performance quarterly through the analysis of the Financial Statistical Report (FSR) submitted by the MCOs. Performance is compared to other MCOs. HPO financial staff monitor health plan stability by review of MCO financial statements at least annually, and more frequently if indicated by risk assessment to ensure continued financial solvency and program integrity.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems**.

Health plan/provider characteristics performance measures
Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC and EQRO**

Detailed description of activity: **MCOs are contractually responsible for maintaining adequate provider networks, including specialists and subspecialists to meet the health care needs for the enrollee/members. HHSC evaluates various reports submitted from the MCO and the EQRO's findings from independent surveys and interviews.**

Frequency of use: **Monthly and Annually**

How it yields information about the area(s) being monitored: **Activities provide information that enables HHSC to measure performance and standards for provider network adequacy and management, program structure, and provider profiling.**

Beneficiary characteristics performance measures
Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan EQR, other contractor): **HHSC, State Enrollment Broker, and EQRO**

Detailed description of activity: **Enrollment Broker collects demographics on all enrollees. Using encounter and claims data, record review, and telephone surveys, the EQRO collects a variety of enrollee data, such as, but not limited to: access to care; service and benefit utilization; patient and family demographics, primary language, financial and insurance resources; and household composition.**

Frequency of use: **Annual reports and as needed on an ad hoc basis**

How it yields information about the area(s) being monitored: **Activities provide HHSC with the ability to measure MCO contractual requirements and quality performance indicators as well as provider network adequacy and to identify the health care and financial needs of at-risk populations.**

o. ___X__ Periodic comparison of number and types of Medicaid providers before and after waiver
Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR,other contractor) **HHSC will direct the Enrollment Broker to conduct this analysis with data from TMHP and MCOs.**

Detailed description of activity: **HHSC will compare the number of PCPs and Specialists.**

Frequency of use: **HHSC will conduct an analysis in the new Texas service areas during readiness review and on an annual basis or more frequently if a problem is identified**.

How it yields information about the area(s) being monitored: **This analysis will be an indicator of whether access improved under managed care.**

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **MCOs**

Detailed description of activity: **MCOs will be responsible for conducting provider profiling activities to assess providers' performance using clinical, administrative and member satisfaction indicators of care.**

Frequency of use: **MCOs must conduct provider profiling activities at least annually**.

How it yields information about the area(s) being monitored: **MCOs will use this information to establish benchmarks for areas profiled, and to provide feedback to individual providers on the results of their performance and the overall performance of the provider network.**

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, EQRO and MCOs.**

Detailed description of activity: **The EQRO administers the MCO Administrative interview and Questionnaire**. MCOs are responsible for monitoring provider networks and complaints.

Frequency of use: As needed

How it yields information about the area(s) being monitored: **The EQRO provides HHSC with feedback and critical information relative to the provider network and contractual relationships for all MCOs and identifies such things as adequacy of credentialing and enrollment processes, staffing ratios, and turnover rates for the individual MCO.**

MCOs provide HHSC with reports that identify provider complaints and appeals.

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit has responsibility but has delegated certain monitoring functions to MCO.**

Detailed description of activity: MCOs must require through provider contract provisions that PCPs are accessible to members 24 hours a day 7 days a week. The PCP may have after hour telephone coverage for contacting PCPs. MCOs monitor the provider offices to assure compliance with contract requirements.**. The MCOs conduct monitoring, and Health Plan Operations analyzes the EQRO's CAHPS survey report. EQRO also conducts spot checks to ensure PCP availability for members.**

Frequency of use: **Annually**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems.**

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

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, EQRO, and MCOs**

Detailed description of activity: **The EQRO provides HHSC with reports and Statistics on specialized (ad hoc) requests by utilizing data stored in a comprehensive encounter and claims database. MCOs may conduct focus studies to measure coordination of care and effectiveness of new health care strategies, such as reducing medically unnecessary emergency room visits or monitoring and improving treatment of pharyngitis.**

Frequency of use**: Up to 25 Ad Hoc requests per year; annual focus studies**

How it yields information about the area(s) being monitored: **Ad hoc reporting provides timely, accurate information needed by HHSC to fully evaluate the MCOs outside the regular reports scheduled to fulfill the EQRO contract obligations and scope of work. Focus studies identify successes and processes that can positively impact patient outcomes**.

t. __X___ Other: (please describe) Claims Processing

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): **HHSC, Health Plan Operations Unit**

Detailed description of activity: **HPO Claims Analyst reviews Claims Summary Reports submitted quarterly by the MCOs to assess compliance with performance standard of adjudicating 98 percent of clean claims within 30 days of receipt from providers. Claims Analyst shares the information with HPO Health Plan Managers and posts performance results to the Web.**

Frequency of use: **Quarterly**

How it yields information about the area(s) being monitored: **Analysis will either demonstrate contract compliance/meeting performance standards or trigger need for further analysis of potential problems**.

Section C: Monitoring Results

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

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

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

_X__ This is a renewal request.

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

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

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

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

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

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)

HHSC reviewed the existing waiver and included those monitoring activities mentioned in the waiver in this section. Monitoring activities are grouped according to the subheadings used in Section B.

Consumer Self-Report data

HHSC Monitoring Activities Identified in the Waiver:

(Cld) – this is the citation for the current waiver. For the convenience of CMS, a citation for the current waiver will appear at the beginning of each activity in this section.) HHSC states the EQRO conducts consumer and provider satisfaction surveys. Working in collaboration with the MCOs and the State, the EQRO biannually administers and reports results from the CAHPS member satisfaction survey that measures member satisfaction by individual health plan, based on a statistically significant number of Medicaid managed care members. A statewide CAHPS telephone survey of Medicaid managed care enrollees has been completed by the EQRO. Another CAHPS survey by MCO has also been completed. STAR Program and PCCM Child and Adult Satisfaction Surveys were completed November 2005.

(FIe2) The EQRO uses several survey instruments of particular relevance to special needs populations. The Consumer Assessment of Health Plans Study (CAHPS) is the basic survey tool employed to understand members' assessment of their access to needed care, office wait times, doctor's communication skills, courtesy of physician office staff and of the health plan customer service staff.

The EQRO also includes questions from the Child Health Questionnaire (CHQ) and the Children with Special Health Care Needs (CSHCN) Screener to identify special populations and their perceptions of special needs, access to care, and the quality of health care services they receive. The CSHCN Screener was adapted from questions used on the National Health Interview Survey (NHIS) and the Questionnaire for Identifying Children with Chronic Conditions (QuICCC).

Confirmation it was conducted as described:

X Yes
___ No. Please explain:

Summary of results: **The EQRO used the CAHPS 3.0 Medicaid version with supplemental questions for chronic conditions, additional questions for demographics and household composition. To be a valid survey, the client population had to have nine months continuous enrollment with no more than one month gap in coverage. Emancipated child members and parents/guardians knowledgeable of the child member's health status and care were interviewed, and a minimum of 300 enrollees for each plan/service delivery area/customer service area were sampled. The EQRO used advance notice letters, computer-assisted telephone interviewing (CATI), rotated calls from day to evening, conducted surveys in English and Spanish, took all necessary procedures to ensure generalization, and assessed the characteristics of responders and non-responders. The result was a report of each item, by MCO and by overall program. Composite scores were calculated for areas such as getting needed care, getting care quickly, doctor communication, office staff communication, health plan customer service, care coordination, prescription access, specialty access, and family centered care. Plan comparisons assessed differences between plans in composite scores after controlling for age, gender, health status, race/ethnicity/ and place of residence. Parents and caregivers who have children 11 years of age and older identified by the CSHCN Screener to have a special health care need were asked an additional set of questions about their child's transition from pediatric to adult care. Issues surrounding this transition include the changing of medical needs of the child, the child taking charge of his/her own health care, and changes in insurance. Families were asked if their child's doctors and other health care providers had discussed these issues with them. These questions were adapted from the SLAITS National Survey of Children with Special Health Care Needs II.**

The EQRO completed 3,906 STAR Child surveys, 600 PCCM Child surveys, 2,237 Adult STAR surveys and 600 PCCM Adult surveys.

The child surveys found many similarities between MCO and PCCM respondents with 16 percent of children in MCOs and 17 percent of children in PCCM as having a special health care need using the CSHCN Screener which is higher than the 12 percent population previously estimated for Texas, according to the National Survey of CSHCN. While there are no specific standards or national data for what would constitute an acceptable score for the CAHPS composites, a score of 75 points was used to indicate that families "usually" or "always" had positive experiences with a particular composite. Using this criterion, overall the STAR MCO and PCCM programs performed well in 7 of the 11 CAHPS composites.

The adult surveys found many similarities between the MCO and PCCM respondents as well and the CAHPS scores for both managed care service delivery models were higher than the Medicaid national mean for getting needed care and customer service composites. While there were some

differences among the MCOs in their performance on CAHPS composite scores after controlling for enrollee health status, race/ethnicity and education, the overall CAHPS Health Plan Survey composite scores for STAR MCOs and the PCCM programs were higher than the Medicaid national mean score for the communication with doctors and customer service. The PCCM Program and STAR MCO Program enrollees' ratings for the remaining domains – getting needed care and getting care quickly – showed variation when compared to those of the Medicaid plans reporting to the National Committee for Quality Assurance (NCQA). The variations reflected that PCCM had a higher rating than did the STAR MCO Program. Overall, there were only small levels of variation in satisfaction ratings between PCCM Program and STAR MCO Program enrollees.

Problems identified:

The Child Survey identified that adolescents with special health care needs often received care from doctors who only treat children (58 percent of the STAR MCO and 52 percent in PCCM). Parents indicated that doctors and other health care providers rarely discussed issues relating to their child's transition to adult care and they would have found this very helpful. Another finding of the survey identified that children with special health care needs are enrolling in the program at a higher percentage that expected, based on state estimates (16 percent in the STAR MCO program and 17 percent in the PCCM Program compared to 12 percent in the general Texas population).

The Adult Survey identified that obesity was a major problem among respondents in both the STAR MCO and PCCM Programs, based on their body mass index (BMI) scores (43 percent in STAR MCO and 44 percent in PCCM). These rates are higher than the overall national average which is estimated to be 32 percent by the National Center for Health Statistics.

No problems were identified for either the STAR MCOs or the PCCM Program that required corrective action.

Corrective action (plan/provider level) **None planned.**

Program change (system-wide level)**: New MCO contracts implemented new performance measures and instituted value-based purchasing strategies. These measures will be assessed with outcomes produced in FY 2008 and FY 2009.**

Data Analysis (non-claims)

HHSC Monitoring Activities Identified in the Waiver:

Denials of referral requests:
(Bll(b)) HHSC checked that it reviews denial of referral requests
(Bll(g)) HHSC checked that it reviews denial of referral requests when enrollees believe referrals to specialists are medically necessary.

Confirmation it was conducted as described:

X Yes **However, denials of referral requests were reviewed only upon request for a State Fair Hearing.**

No. Please explain:

Disenrollment requests by enrollee:
(AIVb5iv(c)) HHSC states the Enrollment Broker produces a monthly report showing the number of members who changed MCOs /-PCCM for that month. The report reflects total plan changes in each MCO service area. While the State does not track whether a plan change is requested by an individual who has made previous plan changes, it can be assumed that the total percentage of the STAR population statewide that has changed plans is well under 10 percent.

(AIVb6(a-c)) HHSC checked that the State reviews and approves all MCO/PCCM-initiated requests for enrollee transfers or disenrollments.

(BIVd) HHSC checked that it measures enrollee requests for disenrollment from a capitated plan or PCCM due to capacity issues. HHSC states that the Enrollment Broker reports monthly on plan changes by reason.

Confirmation it was conducted as described:

X Yes **(AIVb6(a-c))**

X No. Please explain:

(Bll(b)) and (Bll(g)) (AIVb5iv(c) Enrollment Broker's monthly reports do not provide enough detail to determine if a trend has occurred and if the trend is as a result of the MCO's actions or lack thereof. However, the report indicates a low percentage of the enrolled population statewide requested plan changes (due to being provided choice up front resulting in a low percentage of defaults).

Summary of results: **(AIVb6(a-c)) HHSC's review of the MCO-initiated requests for enrollee disenrollments is according to policies and procedures. The number of MCO-initiated enrollee disenrollments is low.**

Problems identified: **None.**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **None**

Grievance and appeals data:
(Blld) HHSC checked that it tracks complaints/grievances concerning access issues.

(BIVe) HHSC checked that it tracks complaints/grievances concerning capacity issues.

(GIIa19) HHSC checked that it reviews information on each MCO's appeals as part of the State quality strategy.

(GIId2) HHSC checked that it maintains a log of all grievances and their resolution.

Confirmation it was conducted as described:
X Yes: **HHSC tracked complaints received from the Hotline that were captured in the CITs program; STARLINK and MCOs report complaints that are not tracked by HHSC. MCO appeals reports are reviewed to determine compliance with resolution timeframe requirement.**
____ No. Please explain:

Summary of results/Problems identified/Corrective action (plan/provider level): **It became apparent that there was inconsistency in the way MCOs were reporting complaints and the definition used. HHSC provided reporting template and definition of requirements to ensure consistency.**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **HHSC provided reporting template and definition of requirements to ensure consistency.**

PCP termination rates and reasons:
(BIVf) HHSC states that it reviews the Provider Network Change Report and Provider Termination Report, to determine if there are changes in the provider network that would affect access to care, and review the internal complaint process. This includes the MCO's quarterly Member Complaint Report to look for problems and trends relating to access to care or services from providers or the plan.

(BIVg-h) HHSC checked that it tracks termination rates of PCPs or providers within MCO networks, and reasons for termination.

Confirmation it was conducted as described:
X Yes
____ No. Please explain:

Summary of results: **HHSC reviews the number of PCPs terminated by MCO per service area and the impact on the MCO's network.**

Problems identified: **HHSC identified instances where the number of PCPs terminated (as a result of a group terminating its contract) were high and affected the ratio of PCP per member.**

Corrective action (plan/provider level): **Identified instances did not require a corrective action plan as the network was still adequate. In these situations, HHSC worked with the MCO to ensure that they intensified their recruitment efforts in order that future terminations did not affect access and network adequacy.**

Program change (system-wide level)**: N/A**

Enrollee Hotlines operated by State

HHSC Monitoring Activities Identified in the Waiver:
(FIe1) HHSC states it contracts with STARLink, a statewide, toll-free helpline designed to assist consumers with urgent medical needs who are experiencing significant barriers to receiving health and long term care services. STARLink provides support, education, information and referrals to persons enrolled in or eligible for the STAR program. STARLink works with HHSC, managed care organizations, providers and other appropriate entities to help callers with urgent medical needs get the services they need. STARLink also educates persons about their rights and responsibilities under managed care, including grievance and appeal procedures, so they are able to advocate for themselves. STARLink collects and maintains statistical information on a regional basis regarding calls received by the assistance lines and publishes quarterly reports that identify trends, which help HHSC identify and correct problems.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results: **STARLink resolved complaints, responded to inquiries and made referrals throughout the year to enrollees.**

Problems identified: **Most common complaints and inquiries related to choosing, changing or finding a provider, enrolling or disenrolling from STAR, and Medicaid eligibility.**

Corrective action (plan/provider level): **HHSC did not implement corrective action plans as a result of STARLink's work. STARLink worked with the**

Enrollment Broker, MCOs and providers to help resolve complaints by enrollees.

Program change (system-wide level) **None**

Focused Studies

HHSC Monitoring Activities Identified in the Waiver:

The EQRO and MCOs conduct focused studies addressing STAR enrollees. Recent studies by the EQRO included assessing transitions in the State's managed care service delivery models from PCCM to MCOs and in assessing women's health issues.

Confirmation it was conducted as described:

X Yes, and

X No. Please explain: **See the summary below.**

Summary of results: **In September 2006 (SFY 07), Texas implemented new contracts with MCOs that expanded geographic service delivery coverage areas and brought in new health plans that did not previously serve the Texas Medicaid population. SFY 07 MCO focused studies, analyses and other efforts will be reported to the State in calendar year 2008 via their Quality Assurance and Performance Improvement Annual Report.**

During the SFY 07 transition time period, the EQRO conducted an administrative interview with all MCOs and conducted an assessment of each health plan's Quality Assurance Plan to ensure that it was appropriate and complete. The EQRO findings did not identify any issues or problems that required remedies.

The EQRO also conducted two special surveys for Child and Adult PCCM members transitioning into managed care health plans in the newly created Nueces Service Area. The Child survey identified that 78 percent of child enrollees were able to keep the same doctor they had for over 5 years and almost all respondents were "satisfied" or "very satisfied" with their child's new doctor under the MCO. While most of the respondents understood the new enrollment information they received, 41 percent of new MCO enrollee respondents stated that they were not encouraged to make an appointment with their new doctor. Those MCOs using aggressive outreach techniques had the best results and satisfaction. The Adult transition survey identified respondents who did not recall moving from the PCCM program to the STAR MCO program. These respondents scored much higher in some of the survey domains, which suggests that healthier enrollees may have paid less attention to the transition process and, thus, did not recall the changes in their Medicaid coverage. In addition, the percentage of enrollees without a

personal doctor decreased from 22 percent of enrollees in the PCCM program to 19 percent of enrollees after moving to the STAR MCO program.

Problems identified: **None**

Corrective action (plan/provider level) **None**

Program change (system-wide level) **None**

Measurement of any disparities by racial or ethnic groups

HHSC Monitoring Activities Identified in the Waiver:
(Blln) HHSC checked that it monitors the disparities affecting ethnic and racial minorities in accessing care (e.g. access to emergency rooms, return visits to providers, referral denial rates)

Confirmation it was conducted as described:
X Yes
___ No. Please explain:
Summary of results: **Through data analysis, health plan monitoring, administrative interviews, and a variety of surveys, the EQRO monitors the enrollee demographics and MCO health plan activities and performance through member surveys that collect racial, ethnic, household, and other data that are reported annually.**

Surveys and interviews conducted by the EQRO also identify the internal MCO processes that monitor enrollee rights and service utilization, case management, disease management, member services, and member education. Beginning SFY 2008, MCOs will be tasked to identify children of migrant farm workers for accelerated services and additional outreach.

Problems identified: **Delivering health care to such a diverse population requires MCOs to incorporate strategies that ensure appropriate care is delivered to racial and ethnic minorities. The EQRO, through the course of fulfilling its contract requirements for HHSC, identifies issues or problems. The EQRO will develop recommendations, which are provided to HHSC and MCOs for improvement or correction.**

Corrective action (plan/provider level) **None**

Program change (system-wide level) **None**

Network adequacy assurance submitted by plan

HHSC Monitoring Activities Identified in the Waiver:

(Bllc) HHSC checked that it conducts periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver).

(Bllf) HHSC checked that it monitors long waiting periods to obtain services from a PCP or PCCM.

(Bllo) HHSC checked that it monitors the provider network showing that there will be providers within the distance/travel times standards.

(BIVb) HHSC checked that it monitors provider-to-enrollee ratios

(BIVc) HHSC checked that it monitors PCP or PCCM provider caseload and caseload limits

(BIVf) HHSC requires MCOs to periodically submit geo maps. The State reviews geo maps of provider networks to determine that geographic access requirements are also being met, particularly if significant changes (i.e., reductions) in the provider network are identified, such as loss of an independent practice association (IPA).

(BVIa) HHSC states it monitors continuity and coordination of care through monitoring complaints and assessment of network adequacy reports received annually.

Confirmation it was conducted as described:

__X_ Yes **(Bllc)) (BIVb) (BVIa)**

__X_ No. Please explain: **(B11f), (B11o) (BIVf) (BIVc) This activity was not part of the EQRO's CAHPS. Monitoring of GeoAccess mapping was reinstituted with the implementation of the new STAR Medicaid value-based at-risk contracts in State Fiscal Year (SFY) 2007 (September 1, 2006 through August 31, 2007). These analyses will be conducted based on data files that the MCOs will provide to HHSC. HHSC contracts with an external consultant to conduct a targeted "network adequacy" analysis for all MCO health plans participating in Medicaid. This study is currently in process.**

Beginning September 1, 2007, HHSC will assess whether MCOs are meeting certain performance measures and standards for network access and adequacy. These measures carry financial incentives and disencentives for meeting (or not meeting) the standards set by HHSC.

Summary of results: **(Bllc) (BIVb) CAHPS surveys and HEDIS performance indicators that relate to access to care are included as part of the annual EQRO reports. HHSC also utilizes reports provided by the Enrollment Broker to monitor the provider-to-enrollee ratios. (BVIa) Continuity of Care**

and coordination of care are monitored during the MCO's annual quality assurance and performance improvement review and administrative interview process conducted by the EQRO. HHSC will review provider and member complaints as they are received.

Problems identified: **None**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **None**

Ombudsman

HHSC Monitoring Activities Identified in the Waiver:
(GIIa20) HHSC checked that it has ombudsman programs to assist enrollees in the appeals, grievance, and fair hearing process.

Confirmation it was conducted as described:
X Yes
___ No. Please explain: Detailed description of activity

Summary of results: **HHSC has an Ombudsman office that makes referrals to the Resolution Services Section. The Resolution Services Section was established to resolve member and provider complaints. The Resolution Services Section researches complaints after a member or provider has exhausted the appeal process with the MCO.**

Problems identified: **Problems included denial of payment, past 95 day filing deadline and no authorization.**

Corrective action (plan/provider level): **The Resolution Services Section worked with the MCO, providers and/or members to resolve complaints.**

Program change (system-wide level): **None**

On-site review

HHSC Monitoring Activities Identified in the Waiver:
(BVIa) HHSC states continuity and coordination of care is monitored during the MCO's annual performance reviews conducted by the EQRO.

(Cld) HHSC states the EQRO conducts MCO interviews and on-site reviews consistent with CMS protocol.

Confirmation it was conducted as described:
X Yes

___ No. Please explain:

Summary of results: **Continuity and coordination of care is monitored as part of the Quality Assessment and Performance Improvement review and the MCO Administrative Interview conducted by the EQRO.**

In addition to the EQRO on-site interviews with MCOs, HHSC health plan management staff also conduct on-site reviews to address specific issues or complaints, review new processes or procedures implemented by the MCO, or to provide feedback to the MCO about their performance and performance improvement goals.

Problems identified: **None**

Corrective action (plan/provider level) **None**

Program change (system-wide level) **Introduction of the new MCO value-based purchasing contracts that include financial and non-financial incentives and disincentives.**

Performance Improvement Projects

HHSC Monitoring Activities Identified in the Waiver:
(CVIIIb2) HHSC identifies the following PCCM performance improvement projects: Texas Health Steps (THSteps) birthday cards; Members without claims postcards; and CaseFinder (for high utilizers).

Confirmation it was conducted as described:
X Yes, **and**
X___ No. Please explain:

Summary of results: **With the implementation of the new STAR MCO at-risk value-based contracts in SFY 2007 (September 1, 2006), HHSC transitioned to identifying overarching goals and working directly with each MCO to implement service-area and program-specific performance improvement goals. The overarching goals established by HHSC identify targeted outcomes, such as Reduction of Inappropriate ER/ED Utilization, and give the MCOs and HHSC the flexibility to identify sub-goals, outcome objectives, levels of performance improvement over a baseline, etc., to provide improvement on a local (specific service area) level. Interventions are developed that may include improvement of provider networks, increased member outreach and education, improved provider education, improved disease management efforts and care coordination, or overall improvement in MCO processes and procedures to achieve the State's overarching goals and objectives. These goals and sub-goals become part of the MCO contract on an annual basis and can carry financial and non-financial incentives. The**

State determines, on an annual basis, if the MCO will carry forward any of the prior SFY goals, should the negotiated outcomes not be met by the MCO.

Problems identified: **None**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **The implementation of STAR MCO performance improvement overarching goals and sub-goals beginning SFY 2007 (September 1, 2006).**

Performance Measures

HHSC Monitoring Activities Identified in the Waiver:

Access/availability of care:
(CVIIIa6) HHSC states it employs the following methods to monitor PCP availability and member access: geographic mapping to ensure members have access to a PCP within 30 miles or 45 minutes; phone audits to monitor urgent and routine appointment availability standards; scheduling of appointments to ensure pregnant women receive appointments within 14 days; quarterly site audits to monitor wait times; and member complaints.

(FIe) HHSC states that based on assessment of complaints by members or providers, HHSC may conduct special evaluations of an MCO's entire network or selected counties or specialty types.

Confirmation it was conducted as described:

X Yes **and**

X No. Please explain: **Monitoring of Geo Access mapping is a new process implemented by HHSC as part of the new SFY 2007 value-based at-risk purchasing and contracting methodologies for Medicaid MCOs. Starting September 1, 2007, quarterly reports will be produced against the MCO network files to identify shortages in network composition and member access. Additionally, HHSC contracted with an external consultant to assess the adequacy of all MCO networks. This assessment is currently ongoing.**

Summary of results: **At HHSC's direction, the EQRO conducts spot checks that may identify issues related to MCO and provider understanding and compliance with appointment availability within the required contract standards. <u>(Fle)</u> HHSC conducted special evaluations of MCO's network in service areas where problems are identified.**

Problems identified: **Network deficiencies identified as part of a network readiness review are handled on a case-by-case basis. None were noted. The current independent assessment being conducted against the new MCO contract**

requirements is not yet completed. A report on those findings are expected to be delivered to HHSC during SFY 2008.

Corrective action (plan/provider level) **None**

Program change (system-wide level) Implementation of the new STAR MCO value-based at-risk purchasing contracts.

Health plan stability/financial/cost of care:
(CVIIj) HHSC states it uses the Financial/Statistical Report for monitoring and evaluation purposes.

Confirmation it was conducted as described:
X Yes
___ No. Please explain:

Summary of results: **Financial Statistical Reports are used to monitor and evaluate the financial performance of the STAR MCOs. Analysis is done quarterly and annually for accuracy of reported data, medical loss ratios, administrative cost ratios, and net income/loss status. This analysis allows HHSC to identify any potential financial risk situations. Summary data is reported to management in a collective comparative summary by SDA. Potential risk situations are acted upon through conference and audit.**

Problems identified: **Data submitted by one MCO appeared to be artificial. HHSC's contracted external auditor scheduled audit work at the MCO and further assisted the MCO in resolving their data problems.**

Corrective action (plan/provider level): **No corrective action plan was needed because the MCO hired competent staff and immediately began to resolve their problem.**

Program change (system-wide level): **None**

Strategy: Periodic comparison of number and types of Medicaid providers before and after waiver/Profile utilization by provider caseload (looking for outliers)

HHSC Monitoring Activities Identified in the Waiver:
(CVIIIa4) HHSC states PCCM prepares quarterly profiles of individual network providers with panels of at least 1,200 member months (displaying at least the previous four (4) quarters), and mails reports presenting the findings of its profiling activity to each provider. In addition to presenting historical summaries of the provider's own utilization patterns with respect to specific categories of services, the reports prepared by the PCCM provide comparisons of the provider's utilization per enrolled patient to the

aggregate experience of groups of providers designated by the State Agency to serve as normative peer groups. PCPs plus or minus 2 standard deviations from their normative peer group are identified as outliers. Cases are weighted using Johns Hopkins adjusted clinical group (ACG) case mix.

Confirmation it was conducted as described:

___ Yes

X No. Please explain**: In September 2003 (last profile production), HHSC determined that the method and software used for the profiles were not producing reports of much benefit. TMHP began the process of business user requirements, and in Spring 2004, HHSC determined that a variable case management approach (with a performance-based fee) would be more appropriate. HHSC is currently in the formative stages of designing a variable case management approach.**

Summary of results: Nonr

Problems identified: **None – HHSC is currently in the formative stages of designing a vriable case management approach.**

Corrective action (plan/provider level) None

Program change (system-wide level) None

Review of Enrollee Materials

HHSC Monitoring Activities Identified in the Waiver:
(HVd) HHSC states it requires the MCO/PCCM to submit all information that is to be sent to enrollees to the State for approval.

Confirmation it was conducted as described:

X Yes

___ No. Please explain:

Summary of results: **HHSC requires MCOs to submit all information that is to be sent to enrollees for State approval. This includes an ongoing process that requires HHSC review and approval or acceptance of changes in previously approved information. HHSC will also review information prepared by MCOs and PCCM to ensure that a consistent message is communicated to the enrollees.**

Problems identified: **None**

Corrective action (plan/provider level) None

Program change (system-wide level) **In SFY 2007 (September 1, 2006), HHSC has implemented value-based at-risk contracts with MCOs that allow HHSC to assess penalties and sanctions for contract violations, including violations related to marketing and member information and materials.**

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 waivers 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: **Thomas Suehs_______**

c. Telephone Number:_____**512-424-6526**_______

d. E-mail:___**Thomas.Suehs@hhsc.state.tx.us**___

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

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

a._ **X** _The State provides additional services under 1915(b)(3) authority.

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

c.___ 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._ **X** _MCO
b.___ PIHP
c.___ 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.___ Population in the base year data

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

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

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

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

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

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

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

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

For Conversion or Renewal Waivers:

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

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

For R2, there were only six months of actual data available – 7/1/07 thru 12/31/07. Therefore for R2, the spreadsheets only contain six months' worth of member months and actual paid cost. The trend rates on Appendix D5 were projected forward based on an 18-month calculation, per CMS procedures.

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

There was a decrease in Disabled and Blind caseload from R1 to R2 because STAR+PLUS rolled out starting February 2007, and ICM rolled out starting February 2008. The STAR+PLUS and ICM rollouts further impacted the projected amount for Disabled and Blind in P1 because both rollouts will have occurred by the start of P1, July 2008. The trend for Disabled and Blind caseload in P2 is an increase of 6 percent because Disabled and Blind are growing at that rate.

The TANF Related caseload growth from R1 to R2 on a 12 month basis is 7 percent. The projected TANF Related growth from P1 to P2 is 3.8 percent. The growth is primarily from the Children's groups.

d. **_X_** [Required] Explain any other variance in eligible member months from BY/R1 to P2: **None**

e._ **X** _[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.
R1 – July 1, 2006 – June 30, 2007
R2 – July 1, 2007 - June 30, 2008

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a._ **X** _[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: _

None.

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

Costs for behavioral health services in the Dallas Service Area were removed because these services are covered by a behavioral health MCO, North STAR.

____

G. **Appendix D2.A - Administration in Actual Waiver Cost**
[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

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

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

c._**X**__Other (Please explain).

The State allocates the administrative costs to the managed care program, based upon the weighted costs of unduplicated recipient months as a percentage of the total Medicaid recipient months.

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(i) Waiver of the 3 prescription limit for adults, (ii) Adult well-checks, and (iii) Waiver of the 30-day spell of illness for adults – TANF related Medicaid Eligibility Group (MEG)	**$5,020,645, or $0.40 PMPM for TANF-related MEG during R1** **$2,898,200, or $0.43 PMPM for TANF-related MEG during R2**	**9.2% in P1 and 6.4% in P2 for TANF-related MEG**	**$0.47 PMPM in P1 and $0.50 PMPM in P2 for TANF-related MEG**
(i) Waiver of the 3 prescription limit for adults, (ii) Adult well-checks, and (iii) Waiver of the 30-day spell of illness for adults – Disabled and Blind Medicaid Eligibility Group (MEG)	**$18,346,577, or $39.32 PMPM for Disabled and Blind MEG during R1** **$5,686,129, or $32.76 PMPM for Disabled and Blind MEG during R2**	**15.2% in P1 and 7.8% in P2 for Disabled and Blind MEG**	**$37.74 PMPM in P1 and $40.68 PMPM in P2 for Disabled and Blind MEG**
Totals	**$23,367,222 – R1** **$8,584329 – R2**		**$12,721,101 for P1 and $14,308,382 for P2**

b._**X**__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:

Voluntary populations are included in the waiver. The Medicaid Eligibility Group (MEG) "Managed Care - Disabled and Blind" is a voluntary population. The issue of selection bias has been addressed in the waiver cost calculations by using the actual managed care claims experience from this population in developing the projections of future cost.

c._**X**_ 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.___Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

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

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

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

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

Current Initial Waiver Adjustments in the preprint

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

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

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be**

mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

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

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

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

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

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

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

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

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes

brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

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

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

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

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

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

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

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

D.____Other (please describe):

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

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

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

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

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

D.____Other (please describe):

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

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

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

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

1.___ No adjustment was necessary and no change is anticipated.
2.___ An administrative adjustment was made.
i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

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

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

3. Explain any differences:

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

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

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

1.___ GME adjustment was made.
  i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

Method:

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

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

1.___ Payments outside of the MMIS were made. Those payments include (please describe):

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

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
Basis and Method:
1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.
1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

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

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and method:
1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*

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

ii.___ Other (please describe):

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

Basis and Method:

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

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

3.___ Other (please describe):

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

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

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

3.___ Other (please describe):

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

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

the waiver program.

2.___ This adjustment was made:

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

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

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

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

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

3.___ Other (please describe):

Special Note section:

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

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

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

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

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

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

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

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

3.___ Other (please describe):

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

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

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

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

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

1.___ No adjustment was made.

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

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

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

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

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

a. X **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.**

In developing the State Plan Trend rates shown in column J of Appendix D5, HHSC developed projected enrollment and costs by region and risk group. Separate projections were made for capitated services and Fee-for-Service (FFS) services. For HMO capitated services, HHSC began with the current (FY2008) HMO premium rates. The trends used to project rates to P1 and P2 were based on HMO claims and encounter experience for the past several years.

Projections of future FFS Plan service costs were based on the actual FFS experience for managed care clients. Future trend assumptions were based on the recent trends for each of the applicable FFS services.

Based on these projections of enrollment and cost for P1 and P2, HHSC determined the average cost for each MEG for the base period, P1 and P2. From these average cost projections, we then calculated the State Plan Trend factors.

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

   i. _**X**__ State historical cost increases. Please indicate the years on which the rates are based: base years___**2005 to 2007**_________ 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 "time series" method is used. The State's trend assumption includes all components of cost, i.e., utilization, inflation changes in technology, practice patterns, etc.

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

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

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

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

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the

capitation rates. However, GME payments must be included in cost-effectiveness calculations.

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

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

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

2._**X**__An administrative adjustment was made.

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

ii._**X**_ Cost increases were accounted for.

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

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

C._**X**__State Historical State Administrative Inflation. The actual trend rate used is: **___2.0 percent______.** Please document how that trend was calculated:

The administrative cost trend was developed based on recent years' changes in the average administrative cost per client.

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

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

1. Please indicate the years on which the rates are based: base years___**2005 to 2007**____________

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

   “Time series” method is used.

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

R1 to P1 1915(b)(3) trend from Appendix D5 Column U:
Managed Care - Disabled & Blind 15.2 percent
Managed Care - TANF related 9.2 percent

The 1915(b)(3) Service Trend factors shown in column U of Appendix D5 were developed by projecting enrollment and costs for these services by region and risk group. Separate projections were made for the following services provided in managed care: (i) waiver of the three-prescription limit for adults, (ii) adult well check-ups, and (iii) waiver of the 30-day spell of illness for adults.

Projections of future 1915(b)(3) service costs were based on actual historical experience for managed care clients. Future trend assumptions were based on recent years’ trends for each of the applicable services.

Based on these projections of enrollment and cost for P1 and P2, we determined the average 1915(b)(3) services cost for each MEG for the base period, P1 and P2. From these average cost projections, we then calculated the 1915(b)(3) Service Trend adjustment factors.

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. Please account for this adjustment in **Appendix D5**.

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

3.___ Other (please describe):

1.___ **X** 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.

See explanations in the above sections.

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.

The State is projecting increases in program enrollment for P1 and P2, relative to R1 and R2. The primary basis for these projected increases is actual experience. In the past two years, the program has experienced growth. The primary causes of the enrollment growth are economic factors leading to more individuals becoming eligible.

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**:

   In projecting the caseloads used in determining Column I of Appendix D7, HHSC made separate projections by risk group. These were then combined to form the two Medicaid Eligibility Groups (MEGs) used for purposes of waiver reporting.

   The impact of caseload changes on the change in cost of the "Managed Care – Disabled and Blind" MEG is due to the decrease in Disabled and Blind caseload from R1 to R2 because STAR+PLUS rolled out starting February 2007 and ICM rolled out starting February 2008. The assumed caseload growth projections by service delivery area are based on the recent experience of the program.

   The impact of caseload changes on the change in cost for the "Managed Care – TANF Related" MEG is subject to changes in both case mix by service delivery area and case mix by risk group since this MEG comprises multiple risk groups. The assumed caseload growth projections by service delivery area and risk group are based on the recent experience of the program. The TANF Related caseload growth from R1 to R2 on a 12 month basis is 7 percent. The projected TANF Related growth from P1 to P2 is 3.8 percent. The growth is primarily from the Children's groups.

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

   In projecting the average costs used in determining Column I of Appendix D7, HHSC made separate projections of caseloads and costs by region and risk group. The projection of unit costs for each region and risk group are based on the recent actual experience of the plan.

These were then combined to form the two MEGs used for purposes of waiver reporting.

The impact of unit cost changes on the change in average cost of the "Managed Care – Disabled and Blind" MEG is limited to assumed changes in the case mix by region since this MEG consists of a single risk group. The assumed caseload growth rates by region are based on the recent experience of the program.

The projected change in average cost for the "Managed Care – TANF Related" MEG is subject to changes in unit cost case mix by region and case mix by risk group since this MEG comprises multiple risk groups. The assumed unit cost trends by region and risk group are based on the recent experience of the program.

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

   The State did not separately project the cost impact of utilization changes and inflation changes. A trend factor that combined both utilization and inflation components was applied to the historical experience. The trend factors selected in projecting the managed care unit costs are based on the actual experience of the program.

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

No other principal factors.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

ATTACHMENT D

DEFAULT METHODOLOGY

I. MANDATORY MEDICAID MANAGED CARE RECIPIENTS (non-TP 40)

Mandatory Medicaid Managed Care recipients are given a minimum of 30 days to enroll in a Managed Care Organization (MCO) and to select a Primary Care Provider (PCP) within the MCO network. (The process for pregnant individuals who are recipients of TANF/TP 40 is described in section II below.) Recipients are encouraged to select a PCP and MCO by calling the Enrollment Broker's toll-free telephone number, meeting with an outreach field enrollment counselor, or mailing in a completed enrollment form. Recipients who choose a PCP and MCO are excluded from the default enrollment process.

The default processing cycle begins the week before the State-established cutoff date for the following month's enrollment. During that week, the Enrollment Broker passes a list of default candidates and the managed care PCP network roster to the Claims Administrator. The Claims Administrator then researches the claims system to obtain a list of claims (within the past year) for all recipients in the default candidates file, limited to the providers in the managed care PCP network roster. The default process begins when the Enrollment Broker receives the claims history file from the Claims Administrator.

The default process is divided into nine steps. Before each step, the Enrollment Broker determines the MCO choice rate. The choice rate is determined by the number of recipients who have chosen a plan. The Enrollment Broker calculates the proportion of elective enrollments within each Service Area (SA) for each MCO using data from the current and two prior months. For the current month, an internal report is used to calculate the number of recipients who have chosen a plan by the time the default process starts. For the previous two months, the elective monthly enrollment from the confirmed Eligible Report is used.

To the maximum extent possible within the limitation of PCP restrictions on recipient age, gender and geographical proximity consideration, the Enrollment Broker will assign family members to the same PCP and MCO. The order for assigning a recipient to a plan and PCP is determined by prior enrollment history with a plan and PCP, claims history, and finally proximity.

Default Process

The nine steps in the default process for the Mandatory Medicaid Managed Care recipients (non-TP 40) are:

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1. **Family Level, Prior Plan/PCP.** The Enrollment Broker will make assignments at the case level to an MCO and PCP based upon the most recent Medicaid managed care encounter history for the family (that is, everyone in the case). This includes assignments to approved out-of-state plan network PCPs within reasonable geographical proximity to the recipient.

2. **Family Level, Prior Claims History**. The Enrollment Broker will make case level assignments to the plans based upon the most recent traditional Medicaid claims history. If recipients within the case have claims history with a PCP who is contracted to only one plan, then the recipients will be assigned to that particular plan and PCP. This includes assignments to approved out-of-state plan network PCPs within reasonable geographical proximity to the recipient. For providers in multiple plans, the MCO choice proportion will be followed.

3. **Family Level, Proximity (Zip Code)**. The Enrollment Broker will make case level assignments to the MCOs on the basis of geographical proximity to the PCP using the zip code to identify the location of the recipient in relation to the PCP. The three-month prior MCO choice proportion will be followed.

4. **Family Level, Proximity (Zip Code Donut)**. The Enrollment Broker will make case level assignments to the MCOs on the basis of geographical proximity to the PCP within an adjoining zip code (zip code donut). The three-month prior MCO choice proportion will be followed.

5. **Recipient Level, Prior Plan/PCP**. The Enrollment Broker will make recipient assignments to an MCO and PCP based upon the most recent Medicaid managed care encounter history. This includes assignments to approved out-of-state plan network PCPs within reasonable geographical proximity to the recipient. The three-month prior MCO choice proportion will be followed.

6. **Recipient Level, Prior Claims History**. The Enrollment Broker will make recipient level assignments to the MCOs based upon the most recent traditional Medicaid claims history. If a recipient has claims history with a PCP who is contracted to only one plan, then the recipient will be assigned to that particular plan and PCP. This includes assignments to approved out-of-state plan network PCPs within reasonable geographical proximity to the recipient. For PCPs in multiple plans, the MCO choice proportion will be followed.

7. **Recipient Level Proximity (Zip Code)**. The Enrollment Broker will make recipient assignments to the MCOs on the basis of geographical proximity to the PCP. The three-month prior MCO choice proportion will be followed.

8. **Recipient Level Proximity (Zip Code Donut)**. The Enrollment Broker will make assignments to the MCOs on the basis of geographical proximity to the PCP within an

adjoining zip code (zip code donut). The three-month prior MCO choice proportion will be followed.

9. **Final Selection of all remaining recipients**. The Enrollment Broker will run a series of the above proximity steps (by zip code and zip code donut) without limitations, to default recipients to the closest available PCP. Finally, the Enrollment Broker will assign all remaining recipients using adjacent county zip codes, as the proximity selection criteria to default recipients to the closest available PCP.

At the completion of the process, the Enrollment Broker removes any defaulted enrollments for recipients who make a choice before the end of the monthly enrollment period.

II. PREGNANT INDIVIDUALS (RECIPIENTS OF TANF/TP 40)

Mandatory Medicaid Managed Care individuals who are pregnant and who are recipients of TANF/Type Program 40 (pregnant individuals (TP 40)) are given 16 days to enroll in an MCO and to select a PCP within the MCO network. If a pregnant individual (TP 40) has not selected an MCO during the 16-day period, the Enrollment Broker will assign the individual to an MCO through a default process on the 17th day. The MCO will be responsible for assigning a PCP to the individual.

Default Process for Pregnant Individuals (TP40)

The order for assigning a recipient to a plan will be determined using a rotational process based on a daily ratio for each plan (i.e. plans will receive their appropriate share of recipients based on the total number of pregnant individuals (TP40) and the number of MCOs available within a SA on a daily basis).

As for other (non-pregnant) Medicaid Managed Care recipients, the Enrollment Broker determines the MCO choice rate. The choice rate is determined by the number of recipients who have chosen a plan. For pregnant individuals (TP40), the Enrollment Broker calculates the number of elective enrollments within each Service Area (SA) for each MCO using data from the two prior months. Based on the number of prior elective enrollments (as shown on the Confirmed Eligible Report) for the past two months, the plans are ranked in order based on their choice rate. The Enrollment Broker then establishes the whole number assignment for the month. The whole number assignment is a single digit that represents the choice rate rounded up.

Example:

Plan A: 42 percent choice rate – whole number equals 5
Plan B: 28 percent choice rate – whole number equals 3
Plan C: 16 percent choice rate – whole number equals 2
Plan D: 12 percent choice rate – whole number equals 2
Plan E: 2 percent choice rate – whole number equals 1

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Day 1
If seven pregnant individuals (TP40) needed assignment. Based upon the whole number assignment, plan A would receive five assignments and plan B would receive only two. The remaining plans would not receive an assignment for that day.

Day 2
If ten pregnant individuals (TP40) needed assignment. Based on the previous day assignment, Plan B would receive one assignment (to complete the previous day assignment), plan C would receive two assignments, plan D would receive two assignments, plan E would receive one assignment completing the rotation. Then the assignment process for the next rotation would start over and plan A would receive four remaining assignments for that day.

The Enrollment Broker will make daily default assignments for pregnant recipients and send enrollments to SAVERR/TIERS. Any pregnant recipient who makes a choice before the 17th day will be removed from the default process**.** Once assigned to an MCO, a recipient can choose another PCP within the plan by contacting the MCO. If a recipient chooses to move to another plan, the recipient should contact the Enrollment Broker.

The managed care plan must attempt to notify any pregnant recipients assigned to their plan who failed to make a PCP selection by either contacting the member via telephone or written correspondence asking them to make a selection. The MCO should make every attempt to encourage the member to choose a PCP at the same time they arrange the prenatal appointment.

PCP assignment will be made within thirty days but before the plan ID is issued. The MCO must then forward the choice or make the appropriate PCP assignment for the member and forward the selection back to the Enrollment Broker for transmission to SAVERR/TIERS. The managed care plan must then issue a new plan ID card to the member with their newly assigned PCP**.** The MCO must forward either the member's PCP choice or the default assignment to the Enrollment Broker by no later than 30 days from the date they received the special TP40 file.

MCOs must ensure that a pregnant member's prenatal appointment is arranged within 2 weeks from the date they receive the pregnant individual's (TP40) daily enrollment file. The member's appointment must be set within this timeframe, but the actual prenatal visit may occur after. MCOs must submit the default PCP assignment for a pregnant individual (TP40) to the Enrollment Broker within two weeks from the date they receive the individual's enrollment file.

REQUEST FOR ADDITIONAL INFORMATION
Managed Care Programs
MCO, PIHP, PAHP and PCCM
1915(b)

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the MCO in the Texas Star + Plus waiver program retains 100 percent of the payments. Does the MCO retain all of the Medicaid capitation payments/PCCM case management fees?

   The MCO retains all of the Medicaid capitation payments.

   Does the entity participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

   No.

   If the MCO is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   Not Applicable.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of the Medicaid capitation payment/PCCM case management fee for the MCO is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment/PCCM case management fee. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

   The State share comes from general revenue funds as appropriated from the Texas Legislature.

Total Estimated Expenditures for Medicaid Capitation Payments / PCCM Case Management Fees were:
7/1/06 – 6/30/07 - $ 2,153.8 Million (State share = $ 844.9 Million)
7/1/07 – 12/31/07 - $ 1,337.9 Million (State share = $ 527.4 Million)*

*** Only six months of actuals are available for this time period at present.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the MCO.

   All payments to MCOs are made as capitation. No supplemental or enhanced payments are made to MCOs.

4. Payments Under Risk Contracts Financial Question. Are there any actual or potential payments to MCOs, PIHPs, PAHPs, or other providers under this waiver/demonstration which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.) If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

   No.

   If managed care contracts include mechanisms such as risk corridors, does the state recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?

   Yes.

5. PCCM financial question. Are there any actual or potential payments to PCCM providers under this waiver/demonstration that supplement or otherwise exceed the standard PCCM case management fee? (These payments could be for such things as incentive arrangements with PCCM providers).

   Not applicable.

   If so, please describe how the state share of the payment is funded. Does the entity retain all of the incentive payment? Does the entity participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the PCCM is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage

of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Not applicable.

6. 1915(b)(3) financial question. Does any provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   Payments do not exceed the reasonable cost of services.