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

September 1, 2008

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

Facesheet

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

The **State** of **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 **STAR+PLUS**. (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

X carried over from previous waiver period. The State:

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

X 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

X carried over from previous waiver period. The State:

X 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 **September 1, 2008** and ending **August 31, 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 she 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.

The State notified the recognized tribes in the state of Texas on March 26, 2008.

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).

Senate Concurrent Resolution 55 (74th Legislature, Regular Session, 1995) required the Texas Health and Human Services Commission to develop a managed care model for the integrated delivery of acute and long-term care services for aged and disabled Medicaid recipients.

STAR+PLUS is the Texas Medicaid model designed to integrate delivery of acute and long-term services through a managed care system. Adult Supplemental Security Income (SSI) recipients and those deemed SSI-eligible for Medicaid purposes must participate in the HMO model. SSI children, under the age of 21, can choose to participate in the STAR+PLUS Program on a voluntary basis.

STAR+PLUS requires two Medicaid waivers - 1915(b) and 1915(c) - in order to mandate participation and to provide home and community-based waiver services. STAR+PLUS became mandatory as of April 1, 1998.

In 2006, STAR+PLUS operated only in Harris County (Houston) and served approximately 63,300 SSI aged and disabled Medicaid recipients. Of these, about half are "dually eligible". This means they are both SSI recipients of Medicaid and Medicare beneficiaries.

Effective February 1, 2007, STAR+PLUS HMOs will operate in four Service Areas: Bexar, Harris, Nueces, and Travis as described in Section A, Part 1, D. Geographic Area Served by Waiver.

Effective February 1, 2007, four MCO plans, two new plans and two existing STAR+PLUS plans, will operate in these Service Areas as described in Section A, Part 1, C. Choice of MCOs, PIHPs, PAHPs, and PCCMs. The PCCM model, which has been an option for Harris County STAR+PLUS eligibles under the age of 21, will no longer be available as of March 1, 2007. Eligibles under the age of 21, who live in the four Service Areas, may voluntarily enroll in STAR+PLUS as of March 1, 2007. These eligibles will

have the option of selecting a HMO in the STAR+PLUS Program or remaining in the traditional fee-for-service Medicaid Program.

As of February 1, 2007, inpatient hospital services will be excluded from the capitation rate paid to STAR+PLUS MCOs and the 30-day spell of illness limitation that applies in fee-for-service will also apply to STAR+PLUS MCO Members. These changes and exceptions are noted in Section A, Part 1, F. Services.

As of May 1, 2007, inpatient behavioral health services resulting from a behavioral health primary diagnosis will be included in the capitation for the Harris Service Area. As of September 1, 2007, inpatient behavioral health services resulting from a behavioral health primary diagnosis will be included in the capitation for the Bexar, Nueces, and Travis Service Areas. Inpatient behavioral health services that are included in the capitation rate paid to STAR+PLUS MCOs will not be subject to the 30-day spell of illness limitation.

Even though the MCOs are not capitated for inpatient hospital services, there is an expectation that through effective management of the member's health care, the MCO will reduce utilization of inpatient services. HHSC has set a target of 22 percent reduction of inpatient costs for each health plan. A portion of each MCO's administrative fee is at risk depending upon the amount of inpatient hospital costs achieved. The maximum at risk is 50 percent of the difference between 15 percent and 22 percent of inpatient savings. MCOs that achieve greater than a 22 percent reduction in inpatient costs may be eligible for an adjustment in future payments, not to exceed 5 percent of the overall MCO capitation amount.

The remaining changes in Section A include references to the MCO Contract amendments for STAR+PLUS MCOs that have been submitted to CMS. For STAR+PLUS MCOs, HHSC executed a contract amendment that included: (a) modifications to the HHSC Uniform Managed Care Terms and Conditions, Attachment A; (b) a new Section 8.3 in Attachment B-1 with scope of work requirements specific to STAR+PLUS MCOs; and (c) revisions to other sections of the Contract, such as Attachment B-1, Section 6 Reimbursement, Incentives, and Disincentives and the Performance Indicator Dashboard.

STAR+PLUS Medicaid Only clients are required to choose an HMO and a Primary Care Provider in the HMO's network. Medicaid only clients receive traditional Medicaid acute care services plus additional services only available to managed care participants. Dual eligibles receive acute care from their Medicare provider of choice.

All Members of a STAR+PLUS HMO receive Medicaid covered long-term services and supports. Services the HMO must provide include the state plan services available to all SSI recipients in the state: Personal Attendant Services and Day Activity and Heath Services. The 1915 (c) Nursing Facility Waiver for the STAR+PLUS program allows the HMO to offer an expanded array of services to assist Members that would otherwise have to enter a nursing facility.

Service coordination is an integral STAR+PLUS service. HMOs must coordinate the client's acute and long-term services, including dual eligible Members' Medicare services.

SSI children may voluntarily participate in the STAR+PLUS HMO model or continue to receive their Medicaid benefits through the traditional Medicaid program. STAR+PLUS adult Members who are not Medicare beneficiaries receive unlimited prescriptions instead of the traditional three prescriptions per month limit. Dual eligible Members receive prescriptions through the Medicare Prescription Drug program.

A. Statutory Authority

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

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

b. **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	**MCO**	**Amerigroup Texas, Inc.**
	MCO	**Molina Healthcare of Texas, Inc.**
	MCO	**Superior Health Plan, Inc.**
Harris Service Area	**MCO**	**Amerigroup Texas, Inc.**
	MCO	**Evercare of Texas, LLC**
	MCO	**Molina Healthcare of Texas, Inc.**
Nueces Service Area	**MCO**	**Evercare of Texas, LLC**
	MCO	**Superior Health Plan, Inc.**
Travis Service Area	**MCO**	**Amerigroup Texas, Inc.**
	MCO	**Evercare of Texas, LLC**

Attachment A-D2 includes a map of the four STAR+PLUS Service Areas (Bexar, Harris, Nueces, and Travis).

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:

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment (SSI adults age 21 and over must enroll in the STAR+PLUS MCO model. In addition, non-SSI clients who qualify for the 1915 (c) Nursing Facility Waiver service must enroll in a STAR+PLUS HMO to receive those services.)

___ 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 (SSI children, under the age of 21, may voluntarily participate in the STAR+PLUS MCO model or continue to receive Medicaid benefits through the traditional Medicaid program.

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

X Mandatory enrollment (SSI adults age 21 and over must enroll in the MCO model. In addition, non-SSI clients who qualify for the 1915 (c) Nursing Facility Waiver service must enroll in a STAR+PLUS HMO to receive those services.)

___ 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:

___ **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))

X **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).

___ **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). STAR+PLUS operates under a 1915(c) Nursing Facility Waiver, as well as a 1915(b) Waiver. Persons eligible for the 1915(c) Nursing Facility Waiver in STAR+PLUS Service Areas must enroll in the STAR+PLUS MCO model to receive the services. All other HCBS waiver clients are excluded.

___ **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.

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.

7. **Self-referrals.**

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

8. Inpatient Services

X The STAR+PLUS expansion is authorized by the 2006-2007 General Appropriations Act, (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 49, 79th Legislature, Regular Session, 2005), which directs the Health and Human Services Commission to utilize cost-effective models to better manage the care of the Medicaid aged, blind, and disabled population. The expanded STAR+PLUS managed health care delivery system will mean more appropriate services and better health care outcomes for the target population, as well as increased efficiencies. All inpatient hospital services will be carved out of the capitation, except for inpatient behavioral health services resulting from a behavioral health primary diagnosis. Because the current STAR+PLUS model includes inpatient behavioral health services and has an established network of providers, and to accommodate the development of provider networks for these services in the STAR+PLUS expansion areas, inpatient behavioral health services resulting from a behavioral health primary diagnosis will be included in the capitation for the Harris Service Area (including

Harris expansion counties) on May 1, 2007, and the Bexar, Nueces, and Travis Service Areas on September 1, 2007. Carved-out inpatient services will continue to be reimbursed under a DRG-based payment system.
For the last eight years, the STAR+PLUS program in Harris County, through its MCOs and their provider networks, has developed an extensive system for handling behavioral health issues for adults and children. The current plans have in-house behavioral health organizations that have been quite effective in coordinating behavioral health services. HHSC did not want to disrupt this service delivery system that is dependent on the coordinated use of inpatient and outpatient services. For that reason, HHSC decided to return inpatient behavioral health services to the list of services covered by STAR+PLUS to assure that the current system in Harris County would not be disrupted and would not create significant problems for clients/members relying on these services. For the Harris Service Area, the inclusion of inpatient behavioral health services will be effective May 1, 2007. For the Bexar, Nueces and Travis Service Areas, the STAR+PLUS MCOs have been asked to develop this network to be available to members by September 1, 2007.

The rates include all inpatient behavioral health services, including services to adults, and the expectation of the state is that the required outcomes are produced through the use of MCO network providers. The MCO, where cost effective and in the best interest of the member, can utilize alternative services as a substitution if these services provide the desired outcomes. (See Joint Medicaid/CHIP HMO Contract, Attachment B-1, Section 8.1.2.2.) Part of the flexibility of the MCO service delivery model is that the MCO can develop networks to meet members' needs that are medically appropriate and responsive to the needs of the members. HHSC does not include non-state plan services in the STAR+PLUS scope of covered services, but the MCO is not restricted to only the delivery of state plan services when alternative services are a cost-effective and medically appropriate response to the needs of the member.

The MCOs will be responsible under their contract to provide the inpatient psychiatric services in the acute general hospital setting. The MCO may choose to provide these services in a more efficient manner by utilizing free standing psychiatric facilities in lieu of acute care inpatient hospitals. HHSC

will include the historical costs for these services in acute general hospitals in the rate development, consistent with CMS policy. For the rates in Harris County, HHSC will recognize free standing psychiatric costs to the extent that they are equal to or less than the cost of an equivalent psychiatric stay in a general hospital.

The STAR+PLUS MCOs are not required to pay for services in a free standing psychiatric facility for persons aged 22-64 years old and these services are not a Medicaid covered benefit. The inpatient psychiatric services in free standing facilities covered by MCOs are substitutes for covered acute inpatient days, and do not represent long-term care Institutions for Mental Disease (IMD) services.

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.

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.

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.

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 has implemented a screening tool, which will be used by the Enrollment Broker during the enrollment process, to identify members that may have special health care needs. MCOs will be 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 pre-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 identifies 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. For the STAR+PLUS program, the MCO must contact each member within 30-days of enrollment to assess any special needs, especially for long-term services and supports.

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.
For STAR+PLUS, 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.

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

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

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

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.

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 5, 2003.

Please see Attachment B, Medicaid Managed Care Quality Assessment and Improvement Strategy.

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):
Please see Attachment C, the Final SFY 2008 and SFY 2009 Deliverables and Work Plan, which outline all major activities to be completed by the EQRO for the State during the time periods specified.

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

2. **Assurances For PAHP program.**

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

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

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

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

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

A. ___ Initial credentialing

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

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

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

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

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

7. __ Other (please describe).

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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.

___ 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.

- **Website/Internet**
- **Print Media**
- **Electronic Media (Television/radio/internet)**

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

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

1.**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.

Uniform Managed Care Contract
8.1.6 Marketing and Prohibited Practices
The HMO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract, and the HHSC Uniform Managed Care Manual.

Uniform Managed Care Manual
Chapter 4.3 Uniform Marketing Policies and Procedures Manual Page 18 of 28

PROHIBITED MARKETING PRACTICES
POLICY NO. MP-02.00
Purpose:
To ensure that the MCO is aware of the prohibited Marketing practices.
Policy:
A MCO engaging in prohibited Marketing practices will be considered in violation of the Marketing Policies and Procedures.
The following prohibitions are applicable to each MCO, its Agents, subcontractors, and providers:.
1. Distributing Marketing Materials without prior HHSC approval;
2. Distributing Marketing Materials written above the 6th grade reading level;
3. Offering Incentives or Giveaways valued over $10.00 to potential Members;
4. Providing Incentives or Giveaways to providers for the purpose of distributing them to the MCO's Members or potential Members;
5. Directly or indirectly, engaging in door-to-door, telephone, and other Cold Call Marketing activities;
6. Marketing in or around public assistance offices, including eligibility offices;
7. Using "Spam;"
8. Making any assertion or statement (orally or in writing) that the MCO is endorsed by the CMS, a federal or state government agency, or similar entity;
9. Marketing to persons currently enrolled in another CHIP or Medicaid Managed Care MCO;
10. Inducing or accepting a Member's enrollment or disenrollment;
11. Using terms that would influence, mislead, or cause potential members to contact the MCO, rather than the Administrative Services Contractor, for enrollment;
12. Portraying competitors in a negative manner;
13. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the CHIP and Medicaid Managed Care programs, services or benefits;
14. Making Giveaways conditional based on enrollment with the MCO;
15. Charging members for goods or services distributed at events;
16. Charging members a fee for accessing the MCO's website;
17. Influencing enrollment in conjunction with the sale or offering of any private insurance;
18. Using Marketing Agents who are paid solely by commission;

19. Posting MCO-specific, non-health related materials or banners in provider offices;
20. Conducting member orientation in Common Areas of providers' offices;
21. Allowing providers to solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);
22. Making charitable contributions or donations from Medicaid/CHIP funds;
23. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying HHSC contractors or sub-contractors to send plan specific materials to potential members;
24. Referencing the commercial component of the MCO in any of its CHIP or Medicaid Managed Care Marketing Materials;
25. Discriminating against a Member or potential Member because of race, creed, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, Health Status or existing need for medical care;
26. Assisting with enrollment form or influencing MCO selection.
27. Making false, misleading or inaccurate statements relating to services or benefits of the MCO or the CHIP or Medicaid Managed Care Programs, or relating to the providers or potential providers contracting with the MCO; and
28. Direct Mail Marketing to potential enrollees.

REPORTING ALLEGED MARKETING VIOLATIONS
POLICY NUMBER: MP-03.00
Purpose: To establish a process to ensure the fair and consistent investigation of alleged violations of the Marketing Policies and Procedures.
Policy: Alleged Marketing violations must be reported to HHSC in writing (use the attached Marketing Complaint Form) for investigation. The MCO accused of violating the Marketing Policies and Procedures is required to cooperate with HHSC during the investigation.
HHSC will investigate all reported alleged Marketing violations and take appropriate action. Upon written receipt of any alleged violation(s), HHSC will:
1. Acknowledge receipt, in writing, within five (5) Business Days from the date of the receipt of the alleged violation.
2. Begin investigation within five (5) Business Days from receipt of the alleged violation and complete investigation within 30 calendar days. HHSC may extend the time for investigation if there are extenuating circumstances.
3. Analyze the findings of the investigation and take appropriate action.
4. Notify complainant after appropriate action has been taken.

Actions by HHSC may include liquidated damages as outlined in the UMCC.

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

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

The State 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.

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

2. **Details.**

a. **Non-English Languages**

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

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

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

2. **X** The languages spoken by approximately **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.
Potential enrollees are sent or given an enrollment packet that includes an explanation of managed care. Potential enrollees who call the Enrollment Broker Helpline are provided with information about managed care and their enrollment options. 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 newly enrolled Medicaid household, regardless of program enrollment. The Consumer Guide includes an explanation of managed care and is distributed by the State's Claims Administrator Contractor.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
X contractor (please specify) the Enrollment Broker, who is Texas Access Alliance.

___ 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):**Texas Access Alliance**
(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.
*****

___ 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. The Enrollment Broker participates in community groups, coalitions, and committees that work directly with the special needs population.

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: **Texas Access Alliance**

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.): The program was expanded on April 1, 2007, to include several counties contiguous to Harris County, as well as the Bexar, Travis and Nueces Service Areas. A map showing the STAR+PLUS Service Areas is shown in Attachment A-D2.

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.
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.

The following business rules became effective 01/01/07 and remain in effect:

Purpose
Develop changes to the current enrollment/default systems and processes in order to allow for the enrollment of SSI, deemed SSI and 1915 c Nursing Facility waiver recipients into the new STAR+PLUS model. Withdraw the PCCM STAR+PLUS plan from the Harris SA.

Program Requirements
Plan Codes and Service Areas:

- The new STAR+PLUS model will operate in the STAR SAs of Bexar, Harris, Harris Expansion, Nueces and Travis.
- These STAR+PLUS SAs will consist of the same counties as do the STAR SAs.
- The new STAR+PLUS model will not be implemented at this time in the STAR SAs of Dallas, El Paso, Lubbock or Tarrant.
- The plan codes of the HMOs in the current STAR+PLUS model will be end-dated 123106. These health plans will be assigned new plan codes for the new STAR+PLUS model with a start date of 010107.
- The STAR+PLUS health plans will need to be assigned a long term care provider number and a site ID
- There will be no PCCM plan in the new STAR+PLUS model. The PCCM STAR+PLUS plan code will be end-dated in SAVERR/TIERS 03/31/07.

STAR+PLUS Plan Codes (new codes are shaded yellow)

Service Area	Plan Name	Plan Codes Effective 01/01/06	Plan Codes Effective 01/01/07
Bexar	AMERIGROUP Community Care	N/A	45
	Molina	N/A	46
	Superior HealthPlan	N/A	47
Harris	AMERIGROUP Community Care	77	7P
	Evercare of Texas	78	7R
	Molina	N/A	7S
	Evercare of Texas	7X	N/A
	PCCM	2E	N/A
Harris Expansion	AMERIGROUP Community Care	N/A	54
	Evercare of Texas	N/A	55
	Molina	N/A	58
Nueces	Evercare of Texas	N/A	85
	Superior HealthPlan	N/A	86
Travis	AMERIGROUP Community Care	N/A	19
	Evercare of Texas	N/A	18

Service Area Counties

Core Service Area Name	Counties in Core Service Area
Bexar	Atoscosa
	Bexar
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Harris	Harris
Harris Expansion	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria
Travis	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Travis
	Williamson

Eligible Populations: The Medicaid populations currently mandatory for enrollment in STAR+PLUS will also be mandatory in the new model—with one exception. SSI-related children (under 21) will be voluntary for enrollment in this model. SSI-related children must voluntarily enroll in a STAR+PLUS HMO or return/remain in Traditional Medicaid (fee-for-service.)

A new population eligible for inclusion in the new STAR+PLUS model is the Medicaid Buy-In population. These clients will be designated as Category 1, 3 and 4 and Type Program 02.

Self-declared, enrolled members of federally recognized tribes are voluntary for STAR+PLUS.

"Conditional" members are STAR+PLUS enrollees who enter a nursing home. They maintain their STAR+PLUS member status until they have been in a nursing facility for four months. (The four months do not have to be consecutive. The four months is accumulated over the client's lifetime and starts as of 09/01/00.)

Base Plan	Cat.	Type Program	Description	STAR +
13	03,04	3	MAO RSDI increase, no Medicare	M
13	03,04	12	SSI manually certified adults, no Medicare	M
13	03,04	12	SSI manually certified children <21, no Medicare	V
13	03,04	13	SSI recipient, adults, no Medicare	M
13	03,04	13	SSI recipient, children <21, no Medicare	V
13	03,04	14	MAO clients in 1915 (c) waiver programs, no Medicare	M
13	03,04	18	Disabled Adult Children denied SSI due to increase in RSDI benefits, no Medicare	M
13	03,04	19	Transitional SSI Medicaid, no Medicare	V
13	03,04	22	Early Age Widows/Widowers, no Medicare	M
13	03,04	51	Rider 51 MAO, no Medicare	M
13	03,04	3	MAO RSDI increase, Medicare	M
13	03,04	12	SSI manually certified adults, Medicare	M
13	03,04	12	SSI manually certified children <21, Medicare	V
13	03,04	13	SSI recipient, adults, Medicare	M
13	03,04	13	SSI recipient, children <21, Medicare	V
13	03,04	14	MAO clients in 1915 (c) waiver programs, Medicare	M
13	03,04	18	Disabled Adult Children denied SSI due to increase in RSDI benefits, Medicare	M
13	03,04	19	Transitional SSI Medicaid, Medicare	V
13	03,04	22	Early Age Widows/Widowers, Medicare	M
13	03,04	51	Rider 51 MAO, Medicare	M
13	01	3	MAO RSDI increase, with or without Medicare	M
13	01	12	SSI manually certified, with or without Medicare	M
13	01	13	SSI recipient, with or without Medicare	M
13	01	14	MAO clients in 1915 (c) waiver programs, with or without Medicare	M
13	01	18	Disabled Adult Children denied SSI due to increase in RSDI benefits, with or without Medicare	M
13	01	22	Early Age Widows/Widowers, with or without Medicare	M
13	01	51	Rider 51 MAO, with or without Medicare	M
	01,03,04	02	Medicaid Buy-In Adults (21 and older)	M
	01,03,04	02	Medicaid Buy-In Children (under 21)	V

Base Plan	Cat.	Type Program	Description	STAR +
10	01,03,04	12	SSI manually certified, with or without Medicare, living in a Title XIX facility	C
10	01,03,04	13	SSI recipient, with or without Medicare, living in a Title XIX facility	C
10	01,03,04	14	MAO and deemed SSI with or without Medicare in a Title XIX facility	C

V=Voluntary
M=Mandatory
C=Conditional

- Current eligible SSI and deemed SSI , adult voluntary enrollees of STAR HMOs in Bexar, Harris Expansion and Travis will be required to enroll in the STAR+PLUS model. Their enrollments in their STAR HMOs will end the last day of the month prior to their enrollment into a STAR+PLUS HMO. The Bexar, Harris Expansion and Travis SAs are the only SAs which currently have SSI voluntarily enrolled HMO members and which will also have the new STAR+PLUS model.

- Current eligible SSI and deemed SSI child voluntary enrollees of STAR HMOs in Bexar, Harris Expansion and Travis will be allowed to voluntarily enroll in the STAR+PLUS model. Their enrollments in their STAR HMOs will end the last day of the month prior to their enrollment into a STAR+PLUS HMO if they choose to enroll. If they do not choose to enroll in a STAR+PLUS HMO, their enrollment in their STAR HMO will end 013107 and they will be returned to Fee-for-Service Medicaid effective 020107.

- Current eligible SSI and deemed SSI adult voluntary enrollees of STAR PCCM in Bexar and Harris Expansion will be required to enroll in the STAR+PLUS model. Their enrollments in the STAR PCCM will end the last day of the month prior to their enrollment into a STAR+PLUS HMO.

- Current eligible SSI-related, child voluntary enrollees of STAR PCCM in Bexar and Harris Expansion will be allowed to voluntarily enroll in the STAR+PLUS model. Their enrollments in the STAR PCCM will end the last day of the month prior to their enrollment into a STAR+PLUS HMO if they choose to enroll. If they do not choose to enroll in a STAR+PLUS HMO, their enrollment in the STAR PCCM will end 013107 and they will be returned to Fee-for-Service Medicaid effective 020107.

- Current 1915c Nursing Facility Waiver recipients will be required to enroll in a STAR+PLUS HMO effective 010107. Any of these clients not making a plan choice by cutoff in December 2006 will be defaulted to a plan effective 010107. The default methodology to be used is the same as described below in “Ongoing Enrollment and Default.”

- Clients in these long term care programs are excluded from participation in the new STAR+PLUS model and will not be sent to the Enrollment Broker as candidates:
    - CLASS (Community Living Assistance and Support Services Program)
    - Nursing Facility
    - DBMD (Deaf-Blind Multiple Disabilities Program)
    - ICF-MR (Intermediate Care Facility for the Mental Retarded)
    - State School
    - HCS (Home and Community based Services Program)
    - TxHmL (Texas Home Living Program)
    - CWP (Consolidated Waiver Program)
    - MDCP (Medically Dependent Children Program)

Initial Implementation--Outside of Harris (County) SA:

- Mandatory candidates who are not enrolled in an HMO will be sent full enrollment packets. These packets will include an explanatory letter as well as a list of frequently asked questions and a comparison chart.

- Mandatory candidates who are enrolled in an HMO or in PCCM will be sent full enrollment packets. These packets will include an explanatory letter as well as a list of frequently asked questions and a comparison chart.

- Mandatory candidates must be sent enrollment materials at least thirty days prior to any default. The day the enrollment packets are mailed is day "0." The mandatory clients who make a choice enrollment prior to cutoff in December 2006 will be enrolled effective January 1, 2007. (Note: the 30 day notification timeframe does not apply to the 1915c Nursing Facility Waiver recipients who are required to enroll by cutoff in December.)

- Mandatory clients who have had at least 30 days to make a choice and who do not make a choice by cutoff in December, will not be defaulted to a health plan effective 010107. There will be no default until cutoff in February 2007. (This does not apply to the 1915c Nursing Facility Waiver recipients who are required to enroll by cutoff in December.)

- Mandatory clients who have had at least 30 days to make a choice and who do not make a choice by cutoff in January, will not be defaulted to a health plan effective 020107. There will be no default until cutoff in February 2007.

- Mandatory clients who have had at least 30 days to make a choice and who do not make a choice by cutoff in February, will be defaulted to a health plan effective 030107.

- Outside of the Harris SA, the standard default will be used. The standard default is based on client choice rates.

- The second default (ongoing default) will occur at cutoff in March 2007 for an April 1 effective date for all mandatory candidates not previously defaulted who have had at least thirty days to choose a plan and who have not chosen a plan.

- Voluntary candidates who are not enrolled in a STAR HMO or STAR PCCM will be sent letters explaining the availability of the STAR+PLUS program, how they may get additional information and how they can enroll. The letter will explain that they have two choices: enrollment in a STAR+PLUS HMO or remaining in Traditional Medicaid. They will also receive a comparison chart and an FAQ.

- Voluntary candidates who are enrolled in a STAR HMO or STAR PCCM will be sent letters explaining the availability of the STAR+PLUS program, how they may get additional information and how they can enroll. The letter will explain that they have two choices: enrollment in a STAR+PLUS HMO or returning to Traditional Medicaid. The letter will explain that continuing enrollment in the STAR HMO or STAR PCCM is not an option. They will also receive a comparison chart and an FAQ.

- Voluntary candidates will not be defaulted at any time.

Initial Implementation—Harris SA:

- Adult enrollees in the current STAR+PLUS model will receive an explanatory letter, an FAQ and a comparison chart. The letter will tell clients that they may change plans if they wish to, but that they do not have to take any action to remain with their current plan. Clients who do not respond to the letter will remain with their current plan.

- Child enrollees in a current STAR+PLUS HMO will receive an explanatory letter, an FAQ and a comparison chart. The letter will explain that the STAR+PLUS program is changing and that they are no longer mandatory enrollees. The letter will explain that they have three choices: enrollment in a new STAR+PLUS HMO, continuing enrollment in their current STAR+PLUS HMO or returning to Traditional Medicaid. Clients who do not respond to the letter will be disenrolled from their current plan and returned to Traditional Medicaid.

- Any HMO STAR+PLUS child enrollee who does not contact the Enrollment Broker by cutoff in January 2007 will be removed from managed care and put back into traditional Medicaid by SAVERR/TIERS effective 020107.

- Child enrollees in the current PCCM STAR+PLUS plan will receive a full enrollment kit including an FAQ. The letter will explain that the STAR+PLUS program is changing and that they are no longer mandatory enrollees. It will also explain that if the client wants to continue in the STAR+PLUS program, PCCM is no longer an option and they must choose a new plan. The letter will explain that they have two choices: enrollment in a STAR+PLUS HMO or returning to Traditional Medicaid.

- Child enrollees who do not respond to the initial letter will be sent a reminder letter.

- Any PCCM STAR+PLUS child enrollee who does not choose a new plan or does not contact the Enrollment Broker by cutoff in January 2007 will be removed from managed care and put back into traditional Medicaid by SAVERR/TIERS effective 020107.

A. Ongoing Enrollment and Default

- Starting November 10, 2006 the enrollment kits sent to mandatory candidates in the Harris SA will include all the new plan choices and will exclude the PCCM STAR+PLUS plan as a choice.

- Mandatory candidates who do not choose a health plan will be defaulted.

- There will be a special default for the Harris SA only. In the Harris SA, all defaults will be assigned to the new plan in the service area for a period of six months or until the new plan reaches 8,000 in total membership in the Harris and Harris Expansion SAs combined—whichever comes first. All other SAs will have the standard default.

- Voluntary candidates will be sent a letter, an FAQ and a comparison chart.

- Voluntary candidates who do not choose a health plan will not be defaulted. They will remain in traditional Medicaid.

Materials Revision and Development

- Current STAR+PLUS enrollment letters and materials will be revised for use in the new STAR+PLUS model

- New STAR+PLUS enrollment letters and materials will be developed for use in the implementation of the new STAR+PLUS model as well as on an ongoing basis.

Enrollment Broker Outreach Effort

- It is HHSC's intention that as many clients as possible be enrolled by choice into the new STAR+PLUS model, rather than by default.
- HHSC expects the Enrollment Broker to use outreach methods, based on past managed care expansion experience, that will most contribute to a high choice rate.
- The 1915c Nursing Facility Waiver recipients who are required to enroll by cutoff in December should be a special target of intensive outreach efforts.

Systems Impacted

- SAVERR

- New plan codes
- New STAR+PLUS SAs
- End-dating the PCCM STAR+PLUS plan (2E) 033107.
- End-dating the Amerigroup (77) and Evercare (78) STAR+PLUS plans
- Closing plan 7X:

Plan Code 7X ended 12/31/2005. Because of the Auto Re-enrolling logic, Evercare members are being re-enrolled into plan code 7X with effective dates after 12/31/05.

1. Need to identify members that have an enrollment segment into Plan Code 7X with From DT or To Date after 12/31/05.

2. If From DT and To Date are after 12/31/05:
   a. The enrollment segment needs to be deleted
   b. Add an enrollment segment using the same Provider, Cty, From DT, To Date and Status but with Plan Code 78.

3. If From Dt is prior to 1/1/06 and To Date is after 12/31/05:
   a. Close the segment effective 12/31/05 and copy the data to populate the "new" enrollment segment.
   b. Add a new enrollment segment using the same Provider, Cty, To Date and Status but with Plan Code 78 and From Dt of 1/1/06.

4. If From Dt is after 12/31/05 and To Date is before 12/31/05:
   a. Create a report with Name and PCN.

5. If From Dt and To Date are prior to 1/1/06:
   a. No action necessary.

- Moving all remaining Amerigroup plan code 77 members (ie. those who have not selected a new STAR+PLUS HMO) to Amerigroup plan code 7P at December 06 cutoff for an effective date of 01/01/07
- Moving all remaining Evercare plan code 78 members (ie. those who have not selected a new STAR+PLUS HMO) to Evercare plan code 7R at December 06 cutoff for an effective date of 01/01/07
- End auto-reenrollment of STAR+PLUS PCCM (2E)
- Allow auto-enrollment of Amerigroup (77) and Evercare (78) former members into Amergroup (7P) and Evercare (7R) after 12/31/06

- TIERS
  - New plan codes for enrollments effective 01/01/07
  - New STAR+PLUS SAs effective 01/01/07
  - End-dating the PCCM STAR+PLUS plan (2E) 033107
  - Closing plan 7X:

Plan Code 7X ended 12/31/2005. Because of the Auto Re-enrolling logic, Evercare members are being re-enrolled into plan code 7X with effective dates after 12/31/05.

1. Need to identify members that have an enrollment segment into Plan Code 7X with From DT or To Date after 12/31/05.

2. If From DT and To Date are after 12/31/05:
   a. The enrollment segment needs to be deleted
   b. Add an enrollment segment using the same Provider, Cty, From DT, To Date and Status but with Plan Code 78.

3. If From Dt is prior to 1/1/06 and To Date is after 12/31/05:
   a. Close the segment effective 12/31/05 and copy the data to populate the "new" enrollment segment.
   b. Add a new enrollment segment using the same Provider, Cty, To Date and Status but with Plan Code 78 and From Dt of 1/1/06.

4. If From Dt is after 12/31/05 and To Date is before 12/31/05:
   a. Create a report with Name and PCN.

5. If From Dt and To Date are prior to 1/1/06:
   a. No action necessary.

- End-dating the Amerigroup (77) and Evercare (78) STAR+PLUS plans 12/31/06
- Moving all remaining Amerigroup plan code 77 members to Amerigroup plan code 7P at December 06 cutoff
- Moving all remaining Evercare plan code 78 members to Evercare plan code 7R at December 06 cutoff
-
- End auto-reenrollment of STAR+PLUS PCCM (2E)
- Allow auto-enrollment of Amerigroup (77) and Evercare (78) former members into Amergroup (7P) and Evercare (7R) after 12/31/06

- TMHP
  - New plan codes for enrollments effective 01/01/07
  - New STAR+PLUS SAs effective 01/01/07
  - End-dating the PCCM STAR+PLUS plan (2E) 033107
  - End-dating the Amerigroup (77) and Evercare (78) STAR+PLUS plans 12/31/06
  - new benefit plan
  - prior authorizations (web portal for inpatient hospitalization and history look up)
  - stat reporting
  - co-insurance edit

- web portal for 3652 CARE form
- access to MESAV
- AIS line
- Access to TxMedCentral
- Notify Ted

- Enrollment Broker
  - New plan codes
  - New STAR+PLUS SAs

- MW
  - MW PPS
  - MW eligibility
    - MW menu

- 1st Health (Vendor Drug)
  - New plan codes

- SAS
  - convert existing SG3 to SG19 effective 010107
  - add STAR+PLUS HMOs to Provider
  - expand exclusion file to include additional new STAR+PLUS counties
  - close all SG7 when the client enrolls in a STAR+PLUS HMO. SG7 to be closed the last day of the month preceding the month of STAR+PLUS enrollment.

- DADS
  - Long term care Provider
  - CSIL

- HHSC
  - Excluded clients list for vendor drug
  - Member data warehouse
  - ACT
  - 372 report

- ICHP

Trading Partners' and Readiness Review Testing
Trading partners will participate in systems testing and HMO readiness review activities prior to implementation.

Definitions

Term or Acronym	Definition
1915 c Nursing Facility Waiver	A program of community based services provided as an alternative to nursing facility care.

Term or Acronym	Definition
Adult enrollee	STAR+PLUS HMO members aged 21 and over.
Child enrollee	STAR+PLUS HMO members aged under 21.
Conditional	STAR+PLUS enrollees who enter a nursing home. They maintain their STAR+PLUS member status until they have been in a nursing facility for four months. (The four months do not have to be consecutive. The four months is accumulated over the client's lifetime and starts as of 09/01/00.)
Deemed SSI	Client eligible for Medicaid after losing SSI eligibility due to earned income increase.
Default	Method by which a mandatory candidate is assigned to a STAR+PLUS HMO by the Enrollment Broker when the candidate has failed to make a health plan choice.
Dual Eligibles	Individuals who qualify for both Medicare benefits and Medicaid assistance. There are two types of dual eligibles: 1) those who receive full Medicaid benefits, and 2) those for whom Medicaid pays for all or part of the Medicare premiums, co-payments and deductibles.
HMO	Health Maintenance Organization. An organization that delivers and manages health services under a risk-based arrangement.
Mandatory STAR+PLUS candidates	Medicaid clients aged 21 and over who live in a STAR+PLUS Service Area and who are in a type program and category of assistance eligible for STAR+PLUS. These clients are required to enroll in a STAR+PLUS HMO.
Medicaid Only	(MAO) Clients who participate in Medicaid programs where no financial assistance is awarded to the client; they receive only medical services based on functional needs.
PCCM	Primary Care Case Management. A type of Medicaid Managed Care program that provides a medical home for Medicaid clients through primary care providers (PCPs) who are paid on a fee-for-service basis.
SAS	Service Authorization System. DADS' system that records service authorizations for long term care services.
SAVERR	System for Application, Verification, Eligibility, Reports, and Referrals. A management information system that contains a database that stores client and case information.
Service Area	(SA) Regions of the State established by the HHSC for the purpose of planning the rollout of Medicaid Managed Care pilot programs.
Spell of Illness	A continuous period of hospital confinement. Successive periods of hospital confinement shall be considered to be continuous unless the last date of the discharge and the date of readmission are separated by at least 60 consecutive days of care.
SSI	Supplemental Security Income. A federal cash assistance program administered by the Social Security Administration for low-income elderly people and people of all ages with

Term or Acronym	Definition
	disabilities. In Texas, SSI recipients are automatically eligible to receive Medicaid.
STAR	State of Texas Access Reform. A Texas Medicaid Managed Care program.
STAR+PLUS	A Texas Managed Care program designed to integrate the delivery of acute and long-term care services through a Managed Care model.
TIERS	Texas Integrated Eligibility Redesign System. Provides administration and management of the Texas Works, Long Term Care and children's insurance programs.
TMHP	Texas Medicaid and Healthcare Partnership (the State's Claims Administrator)
Traditional Medicaid	Fee-for-Service Reimbursement. The traditional health care payment system under which physicians and other providers receive a payment for each unit of service they provide.
Voluntary STAR+PLUS candidates	Medicaid clients aged under 21 who live in a STAR+PLUS Service Area and who are in a type program and category of assistance eligible for STAR+PLUS. These clients are not required to enroll in a STAR+PLUS HMO, but may do so on a voluntary basis.

___ 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 2 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.

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.

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

1. 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 as request. Among the circumstances that 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/PCCM 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/PCCM 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/PCCM may not request a disenrollment of an individual based on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion

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

ii. **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.

iii. **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+PLUS 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. **Assurances.**

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

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

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

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

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

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

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

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 90 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.

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										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
Processing												

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)

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

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

c. X Consumer Self-Report data

X CAHPS (please identify which one(s))

Percent of good access to urgent care
Percent of good access to specialist referral
Percent of good access to routine care
Percent of no delays for an approval
Percent of no exam room wait > 15 minutes
Percent of good access to special therapies
Percent of good access to BH treatment or counseling
Percent of good access to care coordination
Percent 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 the External Quality Review Organization (EQRO)

Detailed description of activity: The EQRO conducts telephone surveys 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)

- 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) STARLink, an HHSC contractor
- Detailed description of activity: STARLink 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 STARLink 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)

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.

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 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 a new Resolution Services Section. The Resolution 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, EQRO, 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. Surveys and interviews cover the following:

- MCO Organizational Structure
- Children's Programs
- Care Coordination and Disease Management Programs
- Quality Assessment and Performance Improvement
- 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 Operational/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 meet minimum net worth requirements throughout the contract period. The Readiness Review Contractor will review organizational structure, MIS systems designs, member and provider materials, provider networks, utilization management systems, claims processing systems, and policies and procedures to demonstrate MCOs' ability to 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.

In addition, the Audit Contractor will conduct risk-based 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 as part of the contract management and incentive approach to be 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]

1) 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.

2) Health Status/Outcomes 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.

3) 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 CAHP 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.

4) 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.

5) 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.

6) 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 of enrollees/members. HHSC evaluates various reports submitted by 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.

7) 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.___ 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):
- Detailed description of activity:
- Frequency of use:
- How it yields information about the area(s) being monitored:

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 and EQRO

Detailed description of activity: The EQRO administers the MCO Administrative Interview and Questionnaire.

Frequency of use: Annually

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.

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: Provider contracts include this requirement. The MCOs conduct monitoring, and Health Plan Operations analyzes the EQRO's CAHP survey report.

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)

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 HHSC website.

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)

NOTE: 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 annually administers and reports results from the Consumer Assessment of Health Plans Surveys (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. The latest annual STAR+PLUS Adult Enrollee CAHPS survey was completed in 2007. The current survey is in their field for 2008. The EQRO also conducted a SFY 2005 Adult Enrollee Unmet Needs Report for STAR+PLUS which was finalized in March 2006 and is also available. (FIe2) The EQRO uses several survey instruments of particular relevance to special needs populations. The CHAPS is employed to understand members' assessment of their access to needed care, office wait times, doctor's communication skills, medical home, courtesy of physician office staff and of the health plan customer service staff. The EQRO also uses the Participant Experience Survey: Elderly/Disabled (PES E/D), Child Health Questionnaire (CHQ), and the Children with Special Health Care Needs (CSHCN) Screener to identify special populations and their perceptions of access to and quality of health care services**.**
Confirmation it was conducted as described:
X Yes
___ No. Please explain:

Summary of results: The EQRO used the CAHPS 4.0 Medicaid version of the survey with supplemental questions for chronic conditions and 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 in 2006. Adults were interviewed, and a minimum of 600 enrollees were targeted for completion. The sample size was selected to (1) provide a reasonable confidence interval for the survey responses, and (2) to ensure there was a large enough sample to allow for comparisons between the two MCOs that participated in the STAR+PLUS program in 2006. 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 EQRO completed the required 600 surveys. The EQRO compiled the results of these surveys into a corresponding report for the specific program population surveyed. The written report narratives and charts focus on areas of quality, access to and getting needed care, care coordination, health behaviors, and client satisfaction. The report technical tables quantify the specific responses to each question; identify numerators and denominators for the survey questions and skip patterns; and provide statistical support for other analyses, such as evaluating client demographics, household composition, etc. 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. Comparisons between MCOs are made after controlling for age, gender, health status, race/ethnicity, and place of residence. Specifically for the STAR+PLUS Program, a stratified random sample of enrollees was selected to participate in the survey. To be eligible for inclusion in the sample, the STAR+PLUS enrollee had to be between the ages of 18 and 65 and enrolled in the STAR+PLUS program for at least nine continuous months in the past year. The continuous enrollment criteria were chosen to ensure that enrollees had sufficient experience to respond to the questions about the program. Also, dual eligibles, enrollees who are eligible for both Medicaid and Medicare, were excluded. A total of 600 telephone surveys were completed for STAR+PLUS, which provided a reasonable confidence interval for the survey responses and sufficient sample size. The survey was conducted by the EQRO between May 2007 and July 2007.

Adult member surveys identified many similarities in demographics among the member populations in STAR+PLUS managed care service delivery programs. The STAR+PLUS survey specifically identified that the non-elderly Medicaid enrollees in the STAR+PLUS Program represented a diverse group. Eighty-two percent of STAR+PLUS respondents reported a specific person – a personal doctor or nurse – from who they received health care (medical home) and 63 percent of those surveyed indicated they did not have a problem getting a personal doctor or nurse that they were happy with. Additionally, areas of potential unmet need for STAR+PLUS non-elderly clients were identified – including, obtaining special equipment to make life easier; help getting groceries; help with laundry; help with housework; and help with other activities of daily living. These areas will again be surveyed in the next STAR+PLUS non-elderly client survey to determine improved satisfaction.

Problems identified: No problems were identified that required corrective action.
Corrective action (plan/provider level) None.
Program change (system-wide level): None.

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 for that month. The report reflects total plan changes in each MCO service area. [STAR+PLUS was only in Harris County in FY 2006 but expanded in FY 2007 into Bexar, Harris, Nueces, and Travis service areas.] The report generated relates all activities of the enrollment broker and the Enrollment Broker covers all Medicaid managed care areas. On average, 0.6 percent of the enrolled population statewide requested a plan change each month [from September 2001 to March 2003]. 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 Medicaid Managed Care population statewide that has changed plans is well under 10 percent. (AIVb6(a-c)) HHSC checked that the State reviews and approves all MCO -initiated requests for enrollee transfers or disenrollments.
(BIVd) HHSC checked that it measures enrollee requests for disenrollment from a capitated plan 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 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 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 a reporting template and a definition of requirements to ensure consistency.
Corrective action (plan/provider level): None
Program change (system-wide level): HHSC provided a reporting template and a 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 an MCO, 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) was 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 the MCO intensified its recruitment efforts so that future terminations would 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+PLUS program. STARLink works with HHSC, MCOs, 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 and helps 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.
Problems identified: The most common complaints and inquiries related to choosing, changing or finding a provider', and enrolling or disenrolling from STAR+PLUS.
Corrective action (plan/provider level): HHSC did not implement corrective action plans as a result of STARLink's work. These member assistance lines 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 conducts focused studies addressing STAR+PLUS (non-SSI) enrollees. Recent studies for STAR+PLUS include: adult depression (August 2003) and a face-to-face survey and record review on Care Coordination (February 2005).
Confirmation it was conducted as described:
X Yes
No. Please explain:
Summary of results: In addition to the focused studies conducted by the EQRO, MCOs conducted focused studies, which included:

- Asthma: Confidence in results reported. Good baseline study that can easily support future improvement projects.
- Comprehensive Diabetes Care: Confidence in results reported. Study establishes baseline for comparisons to future improvement activities.
- Utilization of Services and Asthma Control Among (health plan) Members: Confidence in results reported. Good study to aid in identification of member in need of case management.
- Reducing Medically Unnecessary Emergency Room Visits: High Confidence in the reported results. MCO provided a clear, complete report of a well planned and executed Performance Improvement Plan (PIP), with effectiveness of a specific approach for improvement evaluated.

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 MCO enrollee demographics and health plan activities and performance.

Surveys and interviews conducted by the EQRO also identify the internal MCO processes that monitor enrollee rights and service utilization.
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 develops recommendations, which are provided to HHSC and MCOs.
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

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.
(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 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 survey. Monitoring of GeoAccess mapping has not been conducted across the program since 2002. However, it has been conducted on an exception basis, upon receipt of member or provider complaints and of specialty providers in specific service areas. Monitoring of GeoAccess mapping will be conducted semi-annually under the MCO contract. HHSC discontinued monitoring PCP caseload and limits as it was not an accurate reflection of the PCP's caseload. HHSC did not have knowledge of the other aspects of the providers' business.
Summary of results: (Bllc) (BIVb) CAHPS surveys and HEDIS performance indicators are included as part of the EQRO report. HHSC monitors quarterly the provider-to-enrollee ratios through analyzing reports provided by Enrollment Broker. (BVIa) Continuity of Care and coordination of care are monitored during the MCO's annual performance reviews conducted by the EQRO and on an exception basis upon receipt of member or provider complaints.

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 a new Resolution Services Unit. The Resolution Services Unit was established under the Health Plan Operations Unit in 2004 to resolve member and provider complaints. Resolution Services Unit researches complaints after a member or provider has exhausted the appeal process with the MCO.
The Resolution Section received 251 formal provider and client complaints related to STAR+PLUS from 09/01/04 – 08/31/05.
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.
Problems identified: None
Corrective action (plan/provider level) None.
Program change (system-wide level) None. Annual interview and on-site reviews will continue to be conducted.

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 GeoAccess mapping has not been conducted across the program since 2002.
Summary of results: At HHSC's direction, the EQRO conducted spot checks related to urgent care, routine and pregnant women appointment availability within the required standard. Ninety-two percent of the providers contacted had available appointments within the required performance standard. (Fle) HHSC conducted special evaluations of MCO's network in service areas where problems were identified.
Problems identified: None identified for STAR+PLUS MCOs.
Corrective action (plan/provider level) None
Program change (system-wide level) None

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+PLUS 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. Potential risk situations are acted upon through conference and audit.
Problems identified: No findings related to STAR+PLUS MCOs.
Corrective action (plan/provider level): No corrective action plan was needed.
Program change (system-wide level): None

Review of Enrollee Materials
HHSC Monitoring Activities Identified in the Waiver:
(HVd) HHSC states it requires the MCO 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 required MCOs to submit all information that is to be sent to enrollees for State approval.
Problems identified: None
Corrective action (plan/provider level): None required.
Program change (system-wide level) None

Section D – Cost-Effectiveness

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

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

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

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

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

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

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:
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

__ date of payment.

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

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.

B. 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):

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

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

a. **X** Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1.**X** First Year: **$2.93** per member per month fee **thru 2/28/07**
   2 **X** Second Year:**$0.00** per member per month fee
   3 **X** Third Year: **$0.00** per member per month
   4 **X** Fourth Year: **$0.00** 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.

D. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

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

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

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

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

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

For Conversion or Renewal Waivers:

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

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

c. **X** [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
   There was a general increase in caseload growth over the period. The State expanded the service delivery area (SDA) effective 2/1/07. The service area still includes Harris County, but also includes Harris Contiguous Counties. Harris County and the Harris Contiguous Counties comprise the new Harris SDA. Additional SDAs included in the expansion are Bexar, Nueces, and Travis – which all were effective 2/1/07. Similar to Harris, these SDAs consist of the primary county plus the contiguous counties.

The State will eliminate the STAR+Plus PCCM program effective 3/1/07.

The chart below shows the projected number of enrollees by Service Delivery Area by quarter.

Projected Member Months								
Service Area	**10/06-12/06**	**1/07-3/07**	**4/07-6/07**	**7/07-9/07**	**10/07-12/07**	**1/08-3/08**	**4/08-6/08**	**7/08-9/08**
Bexar SDA	**0**	**92,799**	**138,759**	**141,301**	**143,271**	**144,636**	**145,233**	**146,882**
Nueces SDA	**0**	**40,360**	**60,772**	**61,403**	**62,187**	**62,814**	**63,061**	**63,736**
Travis SDA	**0**	**35,481**	**53,439**	**54,036**	**54,804**	**55,320**	**55,550**	**56,189**
Harris Contiguous	**0**	**34,176**	**51,484**	**52,101**	**52,919**	**53,380**	**53,615**	**54,275**
Harris County	**210,213**	**201,601**	**176,855**	**178,750**	**181,136**	**182,912**	**183,649**	**185,676**
Total	**210,213**	**404,417**	**482,309**	**487,593**	**494,317**	**499,061**	**501,107**	**506,759**

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

e. **X** [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
October 1, 2004 – September 30, 2005.

E. 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**:

State Plan services that were reinstated by the state legislature.

- **Optional Medicaid services for adults over age 21:**
  - **Eyeglasses**
  - **Hearing aids**
  - **Podiatric**
  - **Chiropractic**
  - **Psychological services (from Licensed Psychologists, Licensed Marriage and Family Therapists, Licensed Professional Counselors, and Licensed Masters Social Worker-Advanced Clinical Practitioners)**

Adjustments were made in Appendix D5 for the removal of Prescription Drugs, pursuant to the Medicare Modernization Act of 2003. The State eliminated all inpatient hospital services from the capitation reimbursement effective 2/1/07. Inpatient behavioral health services resulting from a behavioral health primary diagnosis will be added to the capitation reimbursement in Harris SDA on

5/1/07 and will be added to the capitation reimbursement in Bexar, Nueces, and Travis SDAs effective 9/1/07. Note that the projected costs for non-psychiatric inpatient hospital services are still included in Appendix D5 as fee-for-service State Plan costs, because the costs will no longer be included in the capitation rates.

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

F. 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 a blend of caseload and cost percentages.

G. 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.

Texas Fiscal Agent Information:

There are 6 Reports used for Fiscal Agent bucketing. Those Reports are:

- **Report 1 (STMR650A): Cost Reimbursed for Traditional Medicaid Clients**
- **Report 2 (Part of STMR650A): Catastrophic Coverage and Breast & Cervical Cancer Program**
- **Report 3 (STRR650A): Cost Reimbursed for Managed Care Clients**
- **Report 4 (STMR750A): Traditional Medicaid (previously Fee for Service)**
- **Report 5 (STRR750A): Managed Care PCCM and Wrap Around Cost utilized until 02/28/07.**
- **Report 9 (STMR647A): Undocumented and Legal Alien Program**

Each STAT Report has a Section and a Page:

- **The Section tells the eligibility of the client. (Example: Aged-Medicare Related, TANF Under 21 (children), TANF Over Age 20 (adults), etc.)**
- **The Page tells the service that the client received. Example: Hospital – Inpatient Services, Hospital – Outpatient Services, Home Health, Chiropractic Services, etc.**

All Medicaid claims paid by TMHP bucket to a Section and Page on the STAT Report. With the implementation of the Fiscal Agent we had to determine a way for TMHP to map costs to a Strategy for payment and to a Line on the CMS 64 for federal reporting. A crosswalk of the Section and Page of the STAT Reports was created for that purpose.

Because a client's eligibility status determines where costs are bucketed, the State can capture actual costs for the STAR+PLUS waiver in total. The actual costs cannot be captured for each Medicaid Eligibility Group (MEG), however; so total waiver costs are allocated to the MEG level.

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 R2	Membership Adjustments [1]	PMPM Adjustments [2]	Amount Projected to be Spent in Prospective Periods
Medicaid – only				
Inpatient in excess of 30 days	$4,402,142	136.28%	-80.56%	$2,022,039
Annual Adult Well Checks	$163,042	136.28%	17.17%	$451,375
Adult Rx over 3 per month	$11,739,045	136.28%	17.17%	$32,499,045
Total	***$16,304,229*** or $52.47 PMPM	136.28% to P1 35.47% to P2	-9.22% to P1 8.24% to P2	***$34,972,459*** or $47.63 PMPM $51,284,499 or $51.56 PMPM for P2

[1] Reflects expected membership growth due to service area expansion.
[2] Includes PMPM inflation and also an adjustment for the elimination of non-psychiatric inpatient in excess of 30 days.

For 1915(b)(3) services, we assumed the same trend as for state plan services. For state plan services, the 17.2 percent trend factor is calculated as 24 months (10/04-9/05 to 10/06-9/07) at an annual trend rate of 8.2 percent. The 8.2 percent is based on annual trends of 5.5 percent for non-Rx services and 16.0 percent for Rx. The 5.5 percent and 16.0 percent were developed by looking at official budget

trends from HHSC System Forecasting, STAR+PLUS FFS experience, and other historical information provided by HHSC and discussions with the HMOs.

For 1915(b)(3) services, we are using the same trend as for state plan services. Per CMS, we are allowed to use the lower of the historical trends for 1915(b)(3) services and state plan services. Since 1915(b)(3) services in the case of STAR+PLUS are heavily weighted towards Prescription Drugs, it is reasonable to expect that it will have a much higher trend rate than state plan services, which is far less weighted towards Prescription Drugs. Thus, by using the trend rate for state plan services, we are using the lower rate.

To illustrate the estimated total b3 trend, we have divided the b3 services into two categories, HMO b3 Services and Vendor Drug (Rx) services. HMO b3 services are assumed to have the 5.5 percent trend of other non-drug state plan services, and drug trend is projected to be 16 percent. When we take the weighted average of the effective trend we get a higher b3 trend than the weighted State Plan services trend (estimated at 8.2 percent):

	Portion of Total b3 Costs	Trend by Service
Vendor Drug	**72%**	**16.0%**
HMO b3 Services	**28%**	**5.5%**
Weighted Average Trend		**13.1%**

As the table indicates, the 13.1 percent weighted b3 trend is higher than the overall state plan trend of 8.2 percent, and we used the lower 8.2 percent trend in the waiver.

Column U of Appendix D5 also reflects the removal of 1915b3 costs for non-psychiatric inpatient services in excess of 30 days, which makes up approximately 83 percent of 1915b3 costs for all inpatient services in excess of 30 days.

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

c. **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

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

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

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

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

   1. __ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:
   2. __ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) *(i.e., trending from present into the future).*
      i. __ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
      ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was

determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.
   i. Please indicate the years on which the utilization rate was based (if calculated separately only).
   ii. Please document how the utilization did not duplicate separate cost increase trends.

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

Others:

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

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
   i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

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

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

For each change, please report the following:

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

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

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

D.____Other (please describe):

iv.__ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

v.__ Other (please describe):

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

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

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

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States*

should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ An administrative adjustment was made.
    - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
        - A. __ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
        - B. __ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
        - C. __ Other (please describe):
    - ii. ___ FFS cost increases were accounted for.
        - A. __ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
        - B. __ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
        - C. __ Other (please describe):
    - iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
        - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
        - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

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

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section**

D.I.H.a above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. __ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.
2. __ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future),* the State must use the State's trend for State Plan Services.
    i. State Plan Service trend
        A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

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

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

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

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

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

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

Method:

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

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

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

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

Basis and Method:

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

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

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

Method:

1. __ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. __ Determine copayment adjustment based on pending SPA.

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

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

Basis and method:

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

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

Basis and Method:

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

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting

documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

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

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

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

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

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

Special Note section:

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

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

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

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

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

I. 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, projected enrollment and costs by risk group (MEG) were developed. Separate projections were made for capitated services and services provided on a fee-for-service (FFS) basis.

For HMO capitated services, separate trend rates were established for acute care services and long-term care services. The trend for acute care for the HMO component for FFY 2007 (P1) and FFY 2008 (P2) was based on acute care FFS claims experience for the past several years. The long-term care trend was based upon recent FFS claims experience for long-term care claims.

The 17.17 percent trend adjustment is calculated as 24 months (10/04-9/05 to 10/06 - 9/07) at an annual trend rate of 8.2 percent. The 8.2 percent is based on annual trend rates of 5.5 percent for non-Rx services and 16.0 percent for Rx. The 5.5 percent was based on (i) FFS data trends from State Fiscal Years 2002 - 2004, adjusted for programmatic changes which took place during the period, and (ii) State Budget Trends from SFY 2004-2008. The State budget trends include actual trend data for SFYs 2004 and 2005 with projections for subsequent periods.

The 16.0 percent for Rx is based on State Budget Trends and benefit changes due to unlimited scripts under managed care. The 16 percent drug trend is assumed by the State based on recent drug experience. The managed care program allows unlimited prescriptions, where FFS has limits placed on the

benefit. The increase due to the unlimited provision under managed care is covered under programmatic b3, not drug trend.

The State expects the same state plan trend as in the STAR+Plus Renewal Waiver. The trend was developed by looking at official budget trends from HHSC System Forecasting, STAR+PLUS Fee for Service experience, and other historical information provided by HHSC and discussions with the HMOs. Note that the State did assume there would be a one-time adjustment to trend due to the elimination of inpatient hospital services from the capitation reimbursement effective 2/1/07. This one-time adjustment is included in Column L of Appendix D5.

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

See above documentation in I a.

R2 to P1 State Plan Trend From Appendix D5, Column J	**Annual Rate**
STAR+PLUS	**8.2%**

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 year **2005.** 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 method used to determine both the acute care and long term care cost increases is a time series. The cost increase calculation includes any and all factors that lead to increases in costs per member from one period to another.

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

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

3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
   i. Please indicate the years on which the utilization rate was based (if calculated separately only).
   ii. Please document how the utilization did not duplicate separate cost increase trends.

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

Others:

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

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

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

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

For each change, please report the following

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

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

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

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

This adjustment is for the removal of the Medicare Part D dual eligible benefit. Appendix D5 reflects the reduction in this benefit.

The fiscal year (FY) 2005 and 2006 trends were taken from actual data (FY 2005 is September 2004 - August 2005), with part of FY 2006 forecasted. Trends for FY 2007 and FY 2008 were developed using time-series forecasts on our historical caseload and cost data for each risk group (Aged and Medicare Related and Disabled and Blind). Data used for these forecasts was from the Fall of 2005.

Vendor drug trends are developed by group, with Aged, Blind, and Disabled clients broken into two categories, based on whether they receive unlimited prescriptions or are limited to three prescriptions per month. The number of "dual eligibles" was estimated from our existing data, and the overall costs and caseload was removed from the category of Aged, Blind, and Disabled clients.

The Drugs covered by Part D make up 20 percent of the dual eligibles' costs. The drugs that the State will continue to provide to dual eligibles are included in the remaining costs for dual eligibles. The effect of Part D is taken into account in the programmatic changes. It is possible that drug costs will grow at a slower or faster rate under Part D, and there is financial data that

support either lower or higher trends for non-Part D drugs.

E. **X** Other (please describe):

The State expanded the service area effective 2/1/07. The service area still includes Harris County, but also includes Harris Contiguous Counties. Harris County and the Harris Contiguous Counties comprise the new Harris SDA. Additional SDAs included in the expansion are Bexar, Nueces, and Travis. Similar to Harris, these SDAs consist of the primary county plus contiguous counties. Appendix D5 reflects the increase from expanding the service areas.

The State eliminated all inpatient hospital services from the capitation reimbursement effective 2/1/07. Inpatient behavioral health services resulting from a behavioral health primary diagnosis will be added to the capitation reimbursement on 5/1/07 for the Harris SDA, and on 9/1/07 for the Bexar, Nueces, and Travis SDAs. Appendix D5 reflects a one-time adjustment to trend due to the elimination of inpatient hospital services from the capitation reimbursement effective 2/1/07. Note that the projected costs for these services are still included in Appendix D5 as fee-for-service state plan costs, even though the costs will no longer be included in the capitation rates.

The State will eliminate the STAR+PLUS PCCM program effective 3/1/07. Appendix D5 reflects the reduction from eliminating the STAR+PLUS PCCM.

The tables below show the P1 and P2 program adjustments by the above components.

P1 Program Adjustment by Component						
Risk Group	**% of R2 State Plan Costs**	**Remove Medicare Part D Benefit [1]**	**Remove 9 Months PCCM [2]**	**Expand Service Area [3]**	**Remove Inpatient Trend [4]**	**P1 Total Program Change**
Medicaid-only	64%	0.00%	0.00%	-12.39%	-0.72%	-13.02%
Medicare/Medicaid	30%	-20.00%	0.00%	11.64%	-0.72%	-11.33%
PCCM	6%	0.00%	-58.33%	0.00%	0.00%	-58.33%
Total	**100%**					**-15.09%**

[1] The Drugs covered by Part D make up 20 percent of the dual eligibles' costs. The drugs that the State will continue to provide to dual eligibles are included in the remaining costs for dual eligibles.
[2] The State will eliminate the STAR+PLUS PCCM program effective 3/1/07. Therefore, 7 months of the 10/06-9/07 projections are removed to represent only 10/06-2/07 PCCM costs.

[3] The State expanded the service area effective 2/1/07. Therefore, 8 months of the 10/06-9/07 projections also include costs for Harris Contiguous, Bexar SDA, Nueces SDA, and Travis SDA. These adjustments are developed by comparing rates for the expanded service area versus rates for Harris County (current service area). Rates for the expanded service area are based on FFS claims data for members that meet STAR+PLUS eligibility criteria, adjusted to reflect a STAR+PLUS population.
[4] The State expects the same state plan trend as in the STAR + Plus Renewal Waiver. However, the State assumed there would be a one-time adjustment to trend due to the elimination of inpatient hospital services from the capitation reimbursement effective 2/1/07. This adjustment is developed by comparing trend experience for non-inpatient services verses trend experience for all services (including inpatient).

P2 Program Adjustment by Component				
Risk Group	**% of P1 State Plan Costs**	**Remove PCCM [1]**	**Expand Service Area [2]**	**P2 Total Program Change**
Medicaid-only	65%	0.00%	-4.71%	-4.71%
Medicare/Medicaid	32%	0.00%	3.48%	3.48%
PCCM	3%	-100.00%	0.00%	-100.00%
Total	**100%**			**-4.79%**

[1] The State will eliminate the STAR+PLUS PCCM program effective 3/1/07. Therefore, the 10/07-9/08 projections are removed.
[2] The State expanded the service area effective 2/1/07. Therefore, the 10/07-9/08 projections also include costs for Harris Contiguous, Bexar SDA, Nueces SDA, and Travis SDA. These adjustments are developed by comparing rates for the expanded service area versus rates for Harris County (current service area). Rates for the expanded service area are based on FFS claims data for members that meet STAR+PLUS eligibility criteria, adjusted to reflect a STAR+PLUS population.

Subsequent to the initial filing of the waiver renewal (Amendment #2) certain programmatic changes that were to be implemented in P1 and P2 became known. Since these were not known at the time of submission of the renewal they were not included at that time and are in addition to the programmatic changes noted earlier in this section. We have revised this waiver renewal to account for the programmatic changes that will take place in P1 and P2. The first year these changes will be implemented will be 9/1/2007 - 8/31/2008. Thus, they affect one month of P1 and eleven months of P2. These programmatic changes include a Frew adjustment which required a rate increase to physician and professional services. The programmatic changes also included an ambulance rate increase, an increase in payments to state teaching hospitals, a decrease in physician drug rates, a PT/OT/ST rate increase, long term care adjustments such as attendant care and provider rate increases as well as other changes to rates. The table below shows the original and revised program adjustment percentages which are entered into column L of Appendix D5.

	Original Amendment #2	**Revised Amendment #2**
P1	**-15.09%**	**-14.62%**
P2	**-4.79%**	**-0.65%**

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.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
     - D. **X** Other (please describe):

       This is a trend / inflation adjustment, based on previous historical trends of STAR+PLUS. The 4.04 percent "other" factor is a trend/inflation adjustment. The 4.04 percent inflation factor is calculated as 24 months (10/04-9/05 to 10/06-9/07) at an annual trend rate of 2.0 percent. This is the administration trend at a 2 percent annual rate applied for two years (1.02^2 = 1.0404). This trend applies only to Administration.

       The State will terminate the STAR+PLUS PCCM program 3/1/07. Appendix D5 reflects the reduction from eliminating the STAR+PLUS PCCM.

The charts below show the projection for administrative costs in detail. These same charts have been added to the preprint, and the revised pages are attached to this response.

P1 Projection for Administration Costs							
Risk Group	% of Members	R2 PMPM Admin Costs	Admin Trend	Trended Admin Costs	Remove 7 Months PCCM [1]	P1 PMPM Admin Costs	P1 PMPM vs. R2 PMPM
Medicaid-only	36.4%	$13.46	4.04%	$14.01	$0.00	$14.01	4.04%
Medicare/Medicaid	44.3%	$13.46	4.04%	$14.01	$0.00	$14.01	4.04%
PCCM	19.3%	$13.46	4.04%	$14.01	$8.17	$5.83	-56.65%
Total	100.0%	$13.46	4.04%	$14.01	$1.58	$12.43	-7.68%

[1] The State will terminate the STAR+PLUS PCCM program 3/1/07. The trended admin costs of $14.01 represent 12 months of projections (10/06-9/07). Therefore, 7 months of the projections are removed to represent only 10/06-2/07 admin costs.

P2 Projection for Administration Costs							
Risk Group	% of Members	P1 PMPM Admin Costs	Admin Trend	Trended Admin Costs	Remove PCCM [1]	P2 PMPM Admin Costs	P2 PMPM vs. P1 PMPM

Medicaid-only	**36.4%**	**$14.01**	**2.00%**	**$14.29**	**$0.00**	**$14.29**	**2.00%**
Medicare/Medicaid	**44.3%**	**$14.01**	**2.00%**	**$14.29**	**$0.00**	**$14.29**	**2.00%**
PCCM	**19.3%**	**$5.83**	**2.00%**	**$5.95**	**$5.95**	**$0.00**	**-100.00%**
Total	**100.0%**	**$12.43**	**2.00%**	**$12.68**	**$1.15**	**$11.53**	**-7.25%**

[1] The State will terminate the STAR+PLUS PCCM program 3/1/07. The trended admin costs of $8.33 represent projections for 10/07-9/08. Therefore, the projections are removed.

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

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

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

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

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

R2 to P1 1915(b)(3) trend from Appendix D5, Column U:	**Annual Rate**
STAR+PLUS	**8.2%**

The 1915(b)(3) Service Trend factors shown in Column U of Appendix D5 were derived from fee-for-service cost trends.

For 1915(b)(3) services, we assumed the same trend as for state plan

services. For state plan services, the 17.2 percent trend factor is calculated as 24 months (10/04-9/05 to 10/06-9/07) at an annual trend rate of 8.2 percent. The 8.2 percent is based on annual trends of 5.5 percent for non-Rx services and 16.0 percent for Rx services. The 5.5 percent and 16.0 percent were developed by looking at official budget trends from HHSC System Forecasting, STAR+PLUS Fee for Service experience, and other historical information provided by HHSC and discussions with the HMOs.

For 1915(b)(3) services, we are using the same trend as for state plan services. Per CMS, we are allowed to use the lower of the historical trends for 1915(b)(3) services and state plan services. Since 1915(b)(3) services in the case of STAR+PLUS are heavily weighted towards Prescription Drugs, it is reasonable to expect that it will have a much higher trend rate than state plan services, which is far less weighted towards Prescription Drugs. Thus, by using the trend rate for state plan services, we are using the lower rate.

To illustrate the estimated total b3 trend, we have divided the b3 services into two categories, HMO b3 Services and Vendor Drug (Rx) services. HMO b3 services are assumed to have the 5.5 percent trend of other non-drug State Plan services, and drug trend is projected to be 16 percent. When we take the weighted average of the effective trend we get a higher b3 trend than the weighted State Plan services trend (estimated at 8.2 percent):

	Portion of Total b3 Costs	Trend by Service
Vendor Drug	**72%**	**16.0%**
HMO b3 Services	**28%**	**5.5%**
Weighted Average Trend		**13.1%**

As the table indicates, the 13.1 percent weighted b3 trend is higher than the overall State Plan trend of 8.2 percent, and we used the lower 8.2 percent trend in the waiver.

Column U of Appendix D5 also reflects the removal of 1915b3 costs for non-psychiatric inpatient services in excess of 30 days, which makes up approximately 83 percent of 1915b3 costs for all inpatient services in excess of 30 days.

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 year **2005**
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
   The method used to determine the cost increases is a time series.

ii. State Plan Service Trend

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

R2 to P2 State Plan Trend From Appendix D5 Column J:	Annual Rate
STAR+PLUS	**8.2%**
PCCM	**0.0%***
***The State is requesting to terminate the STAR+PLUS PCCM program effective 3/1/07.	

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:
There are no incentives in STAR+PLUS.

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. **X** Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population, ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2. __ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
   1 ___ Other (please describe):
3. __ No adjustment was made.
4. __ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

J. 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.

K. 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 the base year. The primary basis for these projected increases is actual experience. The State expanded the service area effective 2/1/07. The service area still includes Harris County, but also includes Harris Contiguous Counties. Harris County and the Harris Contiguous Counties comprise the new Harris SDA. Additional SDAs included in the expansion are Bexar, Nueces, and Travis. Similar to Harris, these SDAs consist of the primary county plus contiguous counties. The State will terminate the STAR+PLUS PCCM program effective 3/1/07.

L. 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**:
   Caseloads were projected using historical trends. The State expanded the service area effective 2/1/07. The service area still includes Harris County but also includes Harris Contiguous Counties. Harris County and the Harris Contiguous Counties comprise the new Harris SDA. Additional SDAs included in the expansion are Bexar, Nueces, and Travis. Similar to Harris, these SDAs consist of the primary county plus contiguous counties. The State will terminate the STAR+PLUS PCCM program effective 3/1/07.

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**:

   See Section D.I. for explanation of changes in costs.

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.**
   None.