Technical Guide

For the
Section 1915(b)(4) Waiver Application - Fee-for-Service Selective Contracting Program

June, 2012

v1.0

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Application for Section 1915(b)(4) Waiver - Fee-for-Service (FFS) Selective Contracting Program

Introduction

These instructions provide information to assist States in completing the electronic document application (formatted as a Microsoft Office Word 2003 document) for a §1915(b)(4) waiver program to implement a Fee-for-Service (FFS) Selective Contracting Program. Please note that this new application format is not reflected in the web-based §1915(b) waiver system. A State intending to use this new application format should complete it as a MS Word document.

CMS has significantly revised the waiver application from the version currently in use (dated March 2005) in order to streamline the process for seeking such a waiver, to collect only necessary information and to do so in a standardized, transparent fashion. The streamlined §1915(b)(4) application is designed to reduce CMS requests for additional information (RAIs) that can slow the waiver review process.

This guide is intended to provide clear instructions on completing the application in a manner that will facilitate CMS review and timely action on a State's request for a waiver. We hope that it will aid states in designing a FFS selective contracting program by improving understanding of applicable Federal policies and their implications for the design and operation of a FFS selective contracting waiver.

Background

Section 1915(b) of the Social Security Act gives the Secretary of Health and Human Services the discretion to waive a broad range of requirements included in Section 1902 of the Act as may be necessary to enable a State to implement alternative delivery mechanisms for its Medicaid program. However, the Secretary may exercise that discretion only insofar as the alternative delivery mechanism is found to be cost-effective, efficient, and not inconsistent with the purposes of Title XIX of the Act.

In particular, subsection (b)(4) permits a State to restrict the provider from whom Medicaid beneficiaries receive services as long as such restrictions do not substantially impair access to services of adequate quality where medically necessary. This statutory authority (as well as implementing regulations at 42 CFR §431.55) can be used in both fee-for-service as well as managed care arrangements. This application is targeted specifically to selective contracting arrangements that will be paid on a fee-for-service basis.

In order to limit the number of providers rendering covered services to Medicaid beneficiaries, States must submit an initial waiver application to CMS, seeking permission to waive section 1902(a)(23)(A) of the Act, which otherwise permits beneficiaries free choice of providers.

Format of Waiver Application

The §1915(b)(4) FFS selective contracting waiver application is organized in three primary sections:

1. Facesheet: This section provides key information about the waiver program
2. Waiver Program Description: This section contains the formal State request for a waiver, including the specific passages of the Act affected by the State's waiver request. It also addresses all relevant programmatic information, including a detailed description of the proposed selective contracting program, included populations and services, access and quality standards and impacts to beneficiaries.
3. Waiver Cost Effectiveness and Efficiency: This section describes how the waiver program will meet the statutory test of cost-effectiveness and efficiency.

This technical guide uses the application format, but provides detailed item-by-item instructions for completing the application.

Key Features

This application is designed to simplify the waiver application process by:

- Using the same format for initial applications as well as waiver renewals. The State may use this waiver preprint to make an initial request to authorize a new §1915(b) waiver program, as well as to request a renewal or amendment of an existing one.
- Reducing duplication with other requirements. Federal regulations outline specific requirements related to beneficiary protections and for access and quality for all types of waiver programs. As a result, in many places assurances of compliance with regulatory requirements will be sufficient to comply with waiver requirements. Additional information may be required if a State requests waiver of a specific §1902 provision not envisioned in the application.
- Providing clear evaluation criteria. The application provides clear direction on the information needed and criteria used to evaluate waiver requirements.

Technical Instructions

1. Label the MS Word file to identify the State and program (*e.g.*, "Pennsylvania Specialty Pharmacy Waiver").
2. Do not change the wording of items or delete any items except as directed in these instructions.
3. Complete each response as fully as possible.
4. An electronic copy of the MS Word file must be submitted to your State's CMS Regional Office SPA/Waiver mailbox. A hard-copy may also be mailed to the Regional Office.

Facesheet

1. **State:** Enter the State name in space provided

2. **Name/Title of the waiver program**: Enter the name/title of the program as appropriate. If there is more than one program in the waiver, list each program.

3. **Type of request**.
   - Indicate whether the waiver is an initial request by placing an X in the space provided.
   - For an amendment request to an existing waiver, provide the CMS-assigned waiver number in the space provided. Further, indicate which section / part of the application is being modified.
   - For a request to renew an existing waiver, provide the CMS-assigned waiver number in the space provided. Further, indicate whether the existing application (both Section A and Section B) will be replaced in full, carried forward with no changes, or modified (with changes noted by yellow highlighted text.

   NOTE: The CMS-assigned waiver number can be found either in the CMS approval letter or in the MBES system. If you are unsure of the waiver number, please consult with your CMS Regional Office.

4. **Effective Dates.** Indicate in the space provided the requested period of approval in years, along with the beginning and ending dates (in MM/DD/YYYY format).

5. **State Contact.** Provide the name and contact information (phone, fax and email) of the waiver program manager.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation. The State's narrative explanation of its tribal consultation activities must be consistent with the State's approved tribal consultation State Plan amendment.

Program Description. The State's narrative explanation should describe a new program fully, including any relevant historical/contextual information. For an amendment or renewal request, the State should provide a brief history of the program: when it started, how it has performed, along with any new features being added by the amendment or renewal request.

Waiver Services. The State must list all existing State Plan services that will be provided through this selective contracting waiver.

A. Statutory Authority

1. **Waiver Authority.** By placing an X in this section, the State asserts that it is seeking to require enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards consistent with access, quality, and efficient and economic provision of covered care and services.

2. **Sections Waived.** By placing an X in any of the following, the State confirms its desire to waive the specific requirements of §1902 of the Act.

a.___ **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.___ **Section 1902(a)(10)(B) - Comparability of Services**--This section of the Act requires all services for all categorically-needy individuals to be available on a comparable basis. This waiver program may provide services in differing amounts to different beneficiaries.

c.___ **Section 1902(a)(23) - Freedom of Choice**--This section of the Act requires States to permit all beneficiaries to receive covered services from any qualified provider in the State. Under this program, free choice of providers is restricted (except for emergency service providers).

e.___ **Other Statutes and Relevant Regulations Waived** – Any additional waivers the State is seeking (subject to the restrictions below) should be listed in this section, along with a rationale for the waiver.

NOTE: None of the following subsections of §1902 of the Act may be waived under §1915(b) of the Act:

- 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 FQHCs/RHCs
- 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.

B. Delivery Systems

1. **Reimbursement**. If the State intends to pay providers in the waiver program in the same manner as such providers are paid under the approved State Plan, the first item should be selected. If a new payment methodology is envisioned for this waiver program, the second item should be selected, and an explanation of the new payment methodology should be provided.

2. **Procurement**. The State should identify the manner in which the provider(s) of the services under the program were selected.
   - A **Competitive procurement process** involves a Request for Proposal, Request for Application or Invitation for Bid that is formally advertised and targets a wide audience.
   - An **Open cooperative procurement process** permits any provider which meets the State's qualifications to participate.
   - A **Sole Source procurement** process occurs after the State solicits and negotiates with only one source of the covered service. The State must explain how such a procurement process is permitted under and/or consistent with State law.
   - Any other provider selection process that the State has conducted should be identified in **Other**, along with a description of that process.

C. Restriction of Freedom of Choice

1. **Provider Limitations**. The State should identify how many providers of waiver services will be available to beneficiaries by selecting one of the two options in this section. If the State previously requested a waiver of statewideness, the State should indicate in this section the counties or regions of the State where the program will now be implemented.

By selecting one of these options, the State asserts that they will comply with 42 CFR §431.55(f): "Restrictions…on recipients' choice of providers…may not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services."

2. **State Standards.** The Act requires that providers delivering waiver program services must meet, accept, and comply with the State's standards for reimbursement, quality and utilization. Those standards must further be consistent with access, quality and efficient and economic provision of covered care and services. The State should specify if waiver service providers will be held to new or different standards in these areas.

D. Populations Affected by Waiver

1. **Included Populations**. The following waiver populations are defined as follows:
   - **Section 1931 Children and Related Populations** are children including those eligible under §1931, poverty-level related groups and optional groups of older children.
   - **Section 1931 Adults and Related Populations** are adults including those eligible under §1931, poverty-level pregnant women and optional group of caretaker relatives.
   - **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. States should include Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
   - **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
   - **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 §1931 Adult population.
   - **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.
   - **Title XXI CHIP Children** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the Children's Health Insurance Program (CHIP) through the Medicaid program.

2. **Excluded Populations.** This subsection defines specific populations or characteristics of otherwise included populations who will not be affected by the waiver program.
   - **Dual Eligibles** are individuals entitled to Medicare and eligible for some category of Medicaid benefits.
   - **Poverty Level Pregnant Women** are 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.
   - **Individuals with other insurance** include those with commercial or other health insurance coverage
   - **Individuals residing in a nursing facility or ICF/MR** are Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
   - **Individuals enrolled in a managed care program** are Medicaid beneficiaries who receive waiver program services through a managed care delivery system.
   - **Individuals participating in a HCBS Waiver program** are Medicaid beneficiaries who participate in a Home and Community Based Waiver operated under the authority of §1915(c) of the Act.
   - **American Indians/Alaskan Natives** are Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
   - **Special Needs Children** are Medicaid beneficiaries who are special needs children as defined by the State. States must provide a description of the definition used for this excluded population.

- **Individuals receiving retroactive eligibility** are Medicaid beneficiaries receiving the mandatory three month or less period of retroactive eligibility.
- Any other exclusions the State is applying to this waiver program should be identified by placing an X in front of **Other** and explained in narrative.

Part II: Access

The State must ensure that all services covered under the waiver program are available and accessible to beneficiaries being served by the waiver program. Restrictions on beneficiaries' access to emergency services and family planning services are prohibited.

A. Timely Access Standards. The State must describe how timely access to waiver services is ensured, and how those standards are consistent with access, quality and efficient and economic provision of covered care and services. The State should discuss considerations such as distance, travel time, the means of transportation, and physical access for Medicaid enrollees with disabilities.

B. Provider Capacity Standards

1. The State should describe the methods by which it will ensure that there is a sufficient supply of providers to deliver services under the waiver program.

2. Data analyses, such as provider/member ratios, should be provided if available. Any explanation must consider increased enrollment and/or utilization expected under the waiver.

C. Utilization Standards. The State should describe its utilization measurement standards. It should also provide evidence that these standards are consistent with access, quality and efficient and economic provision of covered care and services, and describe its compliance monitoring and corrective action activities, if needed.

Part III: Quality

A. Quality and Contract Monitoring. States are required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary. This part identifies how the State will monitor access, capacity, utilization and quality of services under the waiver program. 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 beneficiary information. The State should describe its quality and utilization standards and provide evidence that these standards are consistent with access, quality and efficient and economic provision of covered care and services.

1. The State should describe its quality measurement standards. It should also provide evidence that these standards are consistent with access, quality and efficient and economic provision

of covered care and services, and describe its compliance monitoring and corrective action activities if needed.

2. The State should explain how it ensures compliance with the timely access standards described in Part II and its corrective action activities if needed.

3. The State should explain how it ensures compliance with the capacity standards described in Part II and its corrective action activities if needed.

B. Coordination and Continuity of Care Standards. If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Part IV: Program Operations

A. Beneficiary Information. The State should describe how beneficiaries will get information about the selective contracting waiver program. This should include any specific processes or procedures necessary to access covered services.

B. Individuals with Special Needs. By placing an X in this section, the State asserts that it has special processes in place for persons with special needs. Those processes should be described in detail.

Section B – Waiver Cost-Effectiveness and Efficiency

The State must demonstrate that waiver cost projections are reasonable and consistent with statute, regulation and guidance. A FFS selective contracting waiver gives the State a more efficient way to deliver services. Therefore, CMS expects that the payment methodologies for waiver services are the same as those in the approved State Plan reimbursement pages.

Cost-effectiveness under a §1915(b)(4) selective contracting waiver simply requires substantiation by the State that selective contracting waiver program costs are less than or equal to the trended FFS costs for the same services in an "any willing provider" environment.

For new waivers, the cost-effectiveness measurement is a projected estimate of the cost of the services provided without the waiver ("pre-waiver") compared to the cost of services provided under the waiver ("waiver").

For renewal or amendment actions, the State should supply data regarding fee-for-service cost trends for comparable services experienced prior to introduction of the selective contracting waiver, outside the geographic region covered by the selective contracting waiver or in the commercial marketplace. This would address the cost and trend disparity between an "any willing provider" delivery system and the selective contracting program.

In its application, and each quarter during the period that the waiver is in operation, the State must demonstrate that the waiver is cost-effective and efficient. The State must project what its Medicaid expenditures for the contracted State Plan services would be, absent the selective contracting waiver, for the each year of the approved waiver period, called Prospective Years (PY). The State must then spend less for those services than what was projected for the duration of the waiver.

CMS will only renew a 1915(b)(4) selective contracting waiver if the State can demonstrate that expenditures for the contracted services were actually less during the waiver approval period than the State's projected expenditures in the absence of the selective contracting waiver.

Efficient and economic provision of covered care and services:

1. The State must describe how the waiver program results in the efficient and economic provision of covered services. Details may include the State's economic or clinical rationale for providing these services to this population under this authority, the State's methodology for developing the trend rates used for projecting costs, or any discrepancies the State chooses to have considered in the review of this data.

2. Waiver expenditure projections:

    - **Waiver Year:** For each waiver year, provide the beginning and ending dates (in MM/DD/YYYY format)

- **Trend Rate:** For years 1 and 2, States may use a projected rate or a percentage derived from historical expenditures for this or a similar population. For years 3 through 5, the trend rate should reflect the State's actual expenditure experience (as reported on the CMS-64).
- **Projected pre-waiver costs** should reflect the costs of providing waiver services under current FFS, "any willing provider" conditions. The trend rate should be used to project costs forward from current actual costs to the beginning of the waiver period.
- **Projected waiver costs** should reflect the costs of providing waiver services under the selective contracting waiver program.
- **Difference** should reflect the difference between the 'pre-waiver' and "waiver" costs. This number must be a positive number in order for the waiver to be considered cost-effective.