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

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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 __Nevada_____ 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 __Dental Benefits Administrator (DBA)_____. (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 D-Cost Effectiveness

__ 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 _X__ replaced in full

___ carried over from previous waiver period. The State:

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

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is _X__ replaced in full

___ carried over from previous waiver period. The State:

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

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

**Effective Dates:** This waiver renewal is requested for a period of 2 years; effective 01/01/2022 and ending 12/31/2023. (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 Theresa Carsten and can be reached by telephone at (775) 684-3655, or fax at (775) 684-3762, or e-mail at theresa.carsten@dhcfp.nv.gov. (Please list for each program)

# Section A: Program Description

## Part I: Program Overview

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

A tribal letter was sent to the inter-tribal council of Nevada on July 23, 2021notifying the tribes of the intent to renew the 1915(b) Dental Prepaid Ambulatory Health Plan (PAHP) Waiver. The tribes did not request a consultation.

**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).*

This 1915(b) Waiver allows a Prepaid Ambulatory Health Plan (PAHP), Dental Benefits Administrator (DBA) to administer/deliver dental services to Medicaid recipients residing in urban Clark and urban Washoe Counties in Nevada. The intent of contracting with the DBA is to strengthen the Nevada Medicaid dental program and improve the dental health of Nevadans by: emphasizing preventative care, early intervention, and appropriate utilization and quality care; enhancing continuity of care through integrated dental, medical, behavioral and social care; ensuring each recipient has access to a dental home; providing enhanced network access to quality providers; monitoring and encouraging appropriate dental utilization through dental disease prevention and outreach/education initiatives; and effectively monitoring program integrity activities.

The DBA began providing services for members on January 1, 2018 after receiving a score of 92.7% in the Readiness Review performed by the External Quality Review Organization (EQRO) vendor for the Division of Health Care Financing and Policy (DHCFP). During its time in operation, the DBA has conducted and/or participated in 1000+ community outreach events, enrolled each member in a dental home, and maintained a network of general dental providers that exceeds the standards set forth in the contract with the State. Nevada has seen an increase in adult utilization of Medicaid-covered dental services that is correlated to the DBA's value-added benefit of dental cleanings for adults. During the COVID 19 statewide shutdown, the DBA experienced a decrease in service numbers which have since returned to pre-pandemic levels. Starting March 18, 2020, the DBA began offering teledentistry services to its members and, as a value-added service, made these services available statewide from March 18, 2020 to June 30, 2020.

In the upcoming waiver period, the DBA will continue with its outreach efforts and participate in pilot projects that seek to improve the dental health of all members. These pilot projects include a value-based payment program, a vital pulp therapy program,

fluoride application through tele-dental visits, and a healthy behavior reward program for recipients ages 0-20 who have not seen a dentist in the past 12 months.

## A. Statutory Authority

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

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

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

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. _X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

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

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

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

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

## B. Delivery Systems

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

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

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

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

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

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

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

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

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

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

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

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

1. **Assurances.**

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

_X_ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.
Recipients enrolled with the DBA are given freedom of choice in selecting a dental provider/dental home within the DBA's network. The DBA is also required to maintain and report on network adequacy/accessibility, including quarterly geo-access mapping and data-driven analysis.

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

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X_ Other: (please describe): The DBA is designed as a single PAHP provider for the urban Clark and urban Washoe counties. Recipients will maintain freedom of choice in selecting a dental provider/dental home within the DBA's network.

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**

_X_ Beneficiaries will be limited to a single provider in their service area (please define service area). Beneficiaries in urban Clark and urban Washoe counties are limited to a single dental PAHP.

___ 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** Limited to the urban Clark and urban Washoe counties by zip code.

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) |
|---|---|---|
| Washoe County (Urban) | PAHP | LIBERTY Dental Plan |
| Clark County (Urban) | PAHP | LIBERTY Dental Plan |

## E. Populations Included in Waiver

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

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

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

__ **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

_X_ **American Indians and Alaskan Natives** who are members of federally recognized tribes except when the MCO is in the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS

__ Mandatory enrollment
_X_ Voluntary enrollment

_X_ **Children With Special Health Care Needs (CSHCN)** are children under the age of 19 who are receiving services through a family-centered, community based, coordinated care system that receives grant fund under section 501(a)(1)(D) of Title V, and are defined by the state in terms of either program participation or special health care needs

__ Mandatory enrollment
_X_ Voluntary enrollment

_X_ **TANF and CHAP Adults Diagnosed as Seriously Mentally Ill (SMI)**

__ Mandatory enrollment
_X_ Voluntary enrollment

_X_ **TANF and CHAP Children Diagnosed as Severely Emotionally Disturbed (SED)**

__ Mandatory enrollment
_X_ Voluntary enrollment

_X_ **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.

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **Other:** Eligible Indians who are eligible as Nevada Medicaid or Nevada Check Up recipients may choose to opt out of enrollment in the DBA.

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

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

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

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

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

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

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

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

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

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

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

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

_X_ **Other** (Please define):

1. Qualified Medicare Beneficiaries (QMB) who are not covered under full Medicaid benefits.
2. Special Low Income Medicare Beneficiaries (SLMB).
3. Qualified Individual Special Low Income Medicare Beneficiaries (QISLMB2).
4. Qualified Disabled Working Individuals (QDWI).
5. Undocumented aliens including non-qualified, undocumented and qualified aliens, who have not met the five-year bar, are eligible for care and services related to the treatment of an approved emergency medical condition.

## F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

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

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

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

The vendor is required to provide a 24 hour per day, 7 days per week after hours call center that can contact a designated dental provider in emergency situations. The vendor shall not require prior authorization for emergency dental services and shall not deny emergency dental services claims submitted by a non-contracted provider.

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

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

_X_ Family planning services are not included under the waiver.

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

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

required to provide FQHC services to the enrollee during the enrollment period.

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

X The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program. The vendor is required to reimburse for services provided by a FQHC.

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.**

___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.**

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

# Section A: Program Description

## Part II: Access

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

## A. Timely Access Standards

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

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

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

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

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

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

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

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

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

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

## B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| ***Area(City/County/Region)*** | ***PCCM-to-Enrollee Ratio*** |
|---|---|
| | |
| | |
| | |

| | |
|---|---|
| | |
| | |
| ***Statewide Average: (e.g. 1:500 and 1:1,000)*** | |

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

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

## C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

a. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.
This PAHP covers dental services only. In accordance with 42 CFR 438.208(a)(20), the State has determined that the implementation of a mechanism for identifying, assessing and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of 438.208, is not applicable given the limited scope of the program.

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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The vendor must furnish services in the same amount, duration and scope as services furnished to recipients under FFS Medicaid as set forth in 42 CFR 440.230. The vendor:

A. Must ensure the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished;

B. May not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the recipient; and

C. May place appropriate limits on a service on the basis of criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The vendor is responsible for covering services related to the prevention, diagnosis and treatment of oral health impairments; the ability to achieve age appropriate growth and development; and the ability to attain, maintain or regain functional capacity in a manner that is no more restrictive than that used in the State Medicaid and CHIP programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans and other State policy and procedures, including the Medicaid Services Manual (MSM).

The role of the vendor is to ensure accessibility and availability to appropriate dental care, provide for continuity of care, and provide quality
care to enrolled recipients. The vendor is required to have a customer service line to assist members with the location of providers, scheduling of appointments, and customer services related to care coordination needs. Requiring members to utilize one contracted vendor still allows members provider choice, with the added benefit of care coordination services.

Provider Selection Process: An RFP was issued on March 8, 2017, #3425, by the Nevada State Purchasing Division and posted on its website at: http://purchasing.nv.gov/. The website is available to all interested bidders, regardless of location, by the internet.
The criteria used for selection was evaluated and scored in accordance with Nevada Revised Statute (NRS) 333.335(3) based upon the following criteria:

Demonstrated competence – 25%
Experience in performance of comparable engagements – 10%
Conformance with the terms of this RFP – 10%
Expertise and availability of key personnel – 10%
Value added benefits, Collaboration with University of Nevada, Las Vegas (UNLV) School of Dental Medicine, demonstration of success with electronic provider enrollment (these were combined into "Other") – 5%
Cost – 15%
Note: Financial stability will be scored on a pass/fail basis.
Bid submissions were reviewed and scored independently by members of the appointed evaluation team and then through consensus scoring, each criteria was scored on a basis of 1 to 10 and totaled, with the award to the highest scoring bidder.

In August 2021, Nevada's State Board of Examiners authorized a one-year extension of the current contract. A competitive procurement process is planned for CY 2022.

# Section A: Program Description

## Part III: Quality

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

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

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

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

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

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

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

2. **Assurances For PAHP program.**

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

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

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

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

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

A. ___ Initial credentialing

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

___ The utilization management system.
___ The complaint and appeals system.
___ Enrollee surveys.

___ Other (Please describe).

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

5. ___ Has an initial and 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:

The DHCFP used the State's open competitive procurement process in selecting a vendor, which is required by the Nevada State Purchasing Department for all state purchases.

Quality and Performance Standards: The role of the vendor is to ensure accessibility and availability to appropriate dental care, provide for continuity of care and provide quality care to enrolled recipients. Recipients benefit from preventive dental care services, the quality and availability of which are monitored and evaluated by the DHCFP in conjunction with the DHCFP's External Quality Review Organization (EQRO) contractor. The vendor is required to work collaboratively with the DHCFP and the EQRO in these quality monitoring and evaluation activities. The vendor is required to designate a lead person to work with the DHCFP on quality management. By virtue of the DHCFP's contract with the EQRO and the federal regulations which set forth the State's mandates for an EQRO, the vendor has provided reporting data and has participated in additional EQRO activities as assigned and required by the DHCFP.

Provider Selection Process: An RFP was issued on March 8, 2017, #3425, by the Nevada State Purchasing Division and posted on their website at: http://purchasing.nv.gov/. The website is available to all interested bidders, regardless of location, by the internet. The criteria used for selection was evaluated and scored in accordance with Nevada

Revised Statute (NRS) 333.335(3) based upon the following criteria:

Demonstrated competence – 25%
Experience in performance of comparable engagements – 10%
Conformance with the terms of this RFP – 10%
Expertise and availability of key personnel – 10%
Value added benefits, Collaboration with University of Nevada, Las Vegas (UNLV) School of Dental Medicine, demonstration of success with electronic provider enrollment (these were combined into "Other") – 5%
Cost – 15%
Note: Financial stability will be scored on a pass/fail basis.

Bid submissions were reviewed and scored independently by members of the appointed evaluation team and then through consensus scoring, each criteria was scored on a basis of 1 to 10 and totaled, with the award to the highest scoring bidder.

## Section A: Program Description

## Part IV: Program Operations

### A. Marketing

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

1. **Assurances**

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

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

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

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

2. **Details**

a. **Scope of Marketing**

1._X_ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers. The vendor is a single PAHP for recipients and therefore does not participate in marketing as it is defined in 42 CFR §438.104.

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

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

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

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

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

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

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

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

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

iii.__ Other (please explain):

## B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

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

2. **Details.**

a. **Non-English Languages**

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

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

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

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

3._X_ Other (please explain): The vendor must participate in state and federal efforts to promote the delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The State has identified the prevalent non-English language in Nevada to be Spanish. 42 CFR

§438.206(c)(2), and the DHCFP require that vendors offer accessible and high quality services in a culturally competent manner.

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.
The vendor notifies all members that free oral interpretation is available for any language. The "Nevada Medicaid Welcome Packet" provided to new members upon enrollment and information listed in the member handbook includes a description about the availability of oral interpretation for any language.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.
Provision of informational materials is sent to enrollees periodically. Enrollees have access to customer service staff who can answer questions about the program materials face-to-face and/or by telephone in a language the member can understand. The vendor is required to maintain a recipient services department that personally assists recipients in obtaining information and services under the vendor's plan.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

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

**c. Enrollee Information**

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

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

## C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

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

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

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

b. **Administration of Enrollment Process**.

_X_ State staff conducts the enrollment process.

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

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

Broker name: _____

Please list the functions that the contractor will perform:

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

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

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

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

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

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

i. ___ Potential enrollees will have____days/month(s) to choose a plan.
ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

_X_ The State **automatically enrolls** beneficiaries

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

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

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

The State of Nevada exempts the following Medicaid recipient groups from mandatory enrollment, but gives recipients the option of voluntarily enrolling in an MCO (and therefore, the PAHP) if they choose:

1. American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes except when the MCO is the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS;
2. Children under the age of 19 years who are receiving services through a family centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs (also known as Children with Special Health Care Needs – CSHCN);
3. TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI); and
4. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED).

___ 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):

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

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

i._X_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
The vendor may request disenrollment of a recipient if the continued enrollment of the recipient seriously impairs the vendor's ability to furnish services to either the particular recipient or other recipients. In addition, the vendor must confirm the recipient has been referred to the vendor's Recipient Services Department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem. Prior approval by the DHCFP of a vendor's request for the recipient's disenrollment is required. Dental Services will then be furnished under FFS.

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

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

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

## D. Enrollee rights.

1. **Assurances.**

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

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

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

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

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

## E. Grievance System

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

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

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

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

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

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

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

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

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

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

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

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

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

b. **Timeframes**

___ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ___ 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.

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

_X_ The grievance procedure is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- _X_ 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)

The DBA has established a grievance and appeal system for recipients and providers. The grievance system is used for any expression of dissatisfaction about a matter other than an adverse benefit determination, as defined in 42CFR§438.400.

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff

composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: at any time for a grievance and within 60 days of the Notice of Action for an appeal. (please specify for each type of request for review)

X Has time frames for resolving requests for review. Specify the time period set: (please specify for each type of request for review)
The vendor is required to resolve each grievance and appeal as expeditiously as the recipient's health condition requires. The DBA allows no more than 30 calendar days from date of receipt to resolve a grievance and no more than 30 calendar days from the date of receipt to resolve an appeal.

X Establishes and maintains an expedited review process for the following reasons: Specify the time frame set by the State for this process
For cases in which a provider indicates or the vendor determines that following the standard timeframe could seriously jeopardize the recipient's life or health or ability to attain, maintain or regain maximum function, the DBA makes an expedited authorization decision and provides a Notice of Action as expeditiously as the recipient's health condition warrants and no later than 72 hours after receipt of the request for service. The DBA may extend the 72 hour time period by up to 14 calendar days if the recipient requests an extension or if the vendor justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's best interest. The DBA provides written notice of the reason for the extension and informs members of their right to file a grievance.

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

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

___ Other (please explain):

## F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

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

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

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

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

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

## Section B: Monitoring Plan

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

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

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

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

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

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

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

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

## I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

| Monitoring Activity | Evaluation of Program Impact | | | | | | Evaluation of Access | | | Evaluation of Quality | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Choice | Marketing | Enroll Disenroll | Program Integrity | Information to Beneficiaries | Grievance | Timely Access | PCP/Specialist Capacity | Coordination/ Continuity | Coverage/ Authorization | Provider Selection | Quality of Care |
| Accreditation for Non-duplication | | | | | | | | | | X | | |
| Accreditation for Participation | | | | | | | | | | | X | |
| Consumer Self-Report data | | | | | | | | | | | | |
| Data Analysis (non-claims) | | | X | X | X | X | X | | | | | |
| Enrollee Hotlines | | | | | | | | | | | | |
| Focused Studies | | | | | | | | | | | | |
| Geographic mapping | X | | | | | | | X | | | X | |
| Independent Assessment | | | | | | | | | X | | | X |
| Measure any Disparities by Racial or Ethnic Groups | | | | | | | | | | | | |
| Network Adequacy Assurance by Plan | | | | | | | | X | | | X | |
| Ombudsman | | | | | | | | | | | | |
| On-Site Review | | | X | | 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 |
| Performance Improvement Projects | | | | | | | | | | | | |
| Performance Measures | | | | | | | | | | | | |
| Periodic Comparison of # of Providers | | | | | | | | | | | | |
| Profile Utilization by Provider Caseload | | | | | | | | | | | | |
| Provider Self-Report Data | | | | | | | | | | | | |
| Test 24/7 PCP Availability | | | | | | | | | | | | |
| Utilization Review | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Other: (describe) | | X | | | | | | | | | | |
| Member Handbook | | | | | | | | | | | | |
| Not Applicable | | | | | | | | | | | | |
| Secret Shopper Survey | | | | | | | X | | | | | |

## II. Details of Monitoring Activities

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

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

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

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

___ NCQA
___ JCAHO
___ AAAHC
_X_ Other (please describe) The contract requires the vendor be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor.

1. The DHCFP DBA Specialist is the responsible personnel.
2. The vendor is responsible for providing their accreditation certificate to the DHCFP.
3. The specialist will review the accreditation submission annually.
4. If the specialist does not receive the accreditation she will follow up with the vendor. If further compliance issues are found, then a corrective action plan will be assigned. If the vendor cannot pass accreditation then the DHCFP will begin the contract termination process.

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

___ NCQA
___ JCAHO
___ AAAHC
_X_ Other (please describe) please reference ***a. other*** above.

c. ____Consumer Self-Report data

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

d. X Data Analysis (non-claims)
___ Denials of referral requests
___ Disenrollment requests by enrollee
___ From plan
___ From PCP within plan
_X_ Grievances and appeals data from the contracted vendor quarterly
___ PCP termination rates and reasons
_X_ Other (please describe):

1. Responsible personnel are the DHCFP Program Integrity Unit, the DHCFP Hearings Unit, and the DHCFP Managed Care and Quality Assurance Unit.
2. The DBA submits the following reports: program integrity reports, reports on services provided, data on race, ethnicity, and primary language spoken, and dispute resolution reports.
3. Reports and data are submitted to the state monthly, quarterly, and on an annual basis.
4. If analysis of reports and/or data indicates a program issue may exist, then the appropriate program specialist will notify the DBA and MCQA program specialist for contractual compliance review.

e. _____ Enrollee Hotlines operated by State

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

g. __X_ Geographic mapping of provider network

1. The responsible personnel is the DHCFP MCQA DBA Specialist.
2. The DBA vendor submits a monthly geo access mapping report to the State that provides an accessibility summary of general dentists and specialists within the network in relationship to where the membership lives.
3. This report is submitted monthly and reviewed by the DHCFP MCQA DBA Specialist.
4. If the analysis of the report indicates a program issue may exist, then the MCQA DBA Specialist follows up with the vendor related to contract compliance and necessary corrective actions.

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

1. The responsible party is the DHCFP, which elects to utilize the subcontracted EQRO vendor to complete the Independent Assessment.
2. The DHCFP contracts the EQRO vendor to complete the access and quality portions of the federally required independent assessment activities. The DHCFP will contract with a separate vendor to complete the cost effectiveness portion of the independent assessment. The vendor is required to work collaboratively with the DHCFP and its vendors in quality monitoring and evaluation activities.
3. This activity will be completed 90 days prior to the end of the waiver period.
4. The DHCFP will utilize the Independent Assessment to analyze whether waiver renewal applications should be submitted to CMS for the next waiver period.

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

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

The DBA must maintain an adequate network that ensures the following:

1. The DHCFP DBA Specialist is responsible for receiving and analyzing if the DBA vendor is meeting network adequacy requirements as outlined within the contract.
2. The vendor must have at least one full-time equivalent (FTE) dentist per 1,500 recipients per geographic service area. The vendor's dental provider network must also include, at a minimum, pediatric dentists, dental hygienists and oral surgeons in each geographic service area sufficient to provide necessary access to care. In clinic practice settings where a dentist provides direct supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing, the vendor may request and the DHCFP may authorize the capacity to be increased as follows: one dental resident per 1,000 recipients per vendor. The dentist shall be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances shall a dentist relinquish or be relieved of direct responsibility for all aspects of care of the recipients enrolled with the dentist.
3. On a quarterly basis, the vendor is required to use geo-access mapping and data-driven analyses to ensure compliance with access standards. The vendor also submits quarterly network adequacy reports and monthly provider count reports to the DHCFP for review.
4. The geo-access map allows the DHCFP specialist to ensure the required time and distance standards are met. Additionally, the

Network Adequacy Reports allow the specialist to identify the provider to member ratios are contractually compliant. If reports indicate a program issue may exist, then the DHCFP DBA Specialist is responsible for following up with the DBA related to non-compliance issues and possible corrective actions.

k. _____ Ombudsman

l. __X__ On-site review
1. The State contracts with an EQRO vendor that conducts an annual compliance review of the DBA.
2. The compliance review is conducted in line with the EQRO protocols. Not all standards are reviewed every year. The DHCFP and the contracted EQRO review specific standards as outlined within the protocol during each year of the 3-year review period. The elements under review for specific years are outlined within our EQR Technical Report.
3. Provider Network Management is reviewed in year 1, Member Services and Experiences is reviewed in year 2, and Managed Care Operations is reviewed in year 3. Findings of the reviews are reported on annually.
4. The on-site review allows the EQRO and DHCFP to ensure that the policies and practices that have been authorized by the DHCFP are in utilization and supported by records review for each standard that is reviewed. If the vendor has findings from the compliance review, then the DHCFP DBA Specialist and EQRO vendor work with the DBA vendor to establish corrective action plans to resolve the issues and bring the vendor back into compliance.

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

n. ____ Performance measures [**Required** for MCO/PIHP]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

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

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

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

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

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

t. __X_ Other: (please describe)
*Member Handbook*:
1. The responsible personnel for review and approval of the member handbook is the DHCFP DBA Specialist.
2. The specialist reviews the handbook to ensure the handbook provides details to the member on how to choose their dental home/provider. The member handbook should also describe how the member can change their dental home/provider. In addition to this review, the handbook is reviewed to ensure that the vendor informs the members of required information as outlined within the contract. At a minimum, the information enumerated below must be included in the member handbook:

- Orienting new members to the vendor's benefits and services including confirmation of the recipient's PDP selection or assigned PDP;
- Role of the primary care dentist;
- The days the office or facility is open and services are available;
- The address and telephone number of the vendor's office or facility;
- How to utilize services in sufficient detail to ensure that recipients understand benefit amount, duration and scope including prior authorization requirements;
- What to do in a dental emergency or urgent dental situation including how to access emergency dental care after hours and on weekends, or out of the service area, inform the member to dial 911 if there is a medical emergency;
- Information on Grievance, Appeals, and Fair Hearing procedures, as specified in 42 CFR 438.10(g);
- A list of current network PDPs, with providers' website URLs, who are and who are not accepting new patients in the recipient's service area and all languages spoken. The list must be in electronic form and include whether its network providers' offices/facilities have

accommodations for people with physical disabilities, including offices, exam room(s) and equipment;

- The provider list located on the vendor's website shall be updated by the vendor monthly;

- Any restrictions on the recipient's freedom of choice among network providers;

- Procedures for changing a PDP;

- Recipient rights and protections as specified in 42 CFR 438.100. The vendor must maintain written policies and procedures for informing recipients of their rights and responsibilities, and must notify recipients of their right to request a copy of these rights and responsibilities;

- Procedures for enrollment and disenrollment;

- Procedure for referral to specialists or other medically necessary dental services;

- Referral for service that the vendor does not cover because of moral or religious objections, the vendor need not provide the information on how or where to obtain the service. The vendor must notify the State and recipient regarding services that meet these criteria and in those instances, the State must provide the information on where and how to obtain the service;

- Any information regarding cost sharing which may apply for a non-covered service;

- How to access Non-Emergency Transportation;

- The vendor is required to provide to the recipient upon request, information on the structure and operation of the vendor and information about provider incentive plans as set forth in 42 CFR 438.3(i) ;

- Information the member needs in order to decide among all relevant treatment options;

- The risk, benefits, and consequences of treatment and non-treatment;

- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions;

- The member handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are provided to the recipient at no costs and a telephone number which the recipient can call to receive assistance in scheduling an appointment;

- Notification of the recipient's responsibility to report any third-party payment service to the vendor and the importance of doing so; and

- Explanation of fraud and abuse and how to report suspected cases of fraud and abuse, including hotlines, e-mail addresses and the address and telephone number of the vendor's fraud and abuse unit.

3. The DHCFP DBA Specialist is responsible for reviewing and approving the member handbook annually, or when any revisions are made by the vendor.
4. If the DHCFP DBA Specialist finds that the member handbook is missing required information she will deny the approval and require the vendor to make the necessary revisions to the handbook.

2. *Marketing:*

1. The responsible party is the DHCFP DBA Specialist.
2. The vendor is required to submit marketing materials to the DHCFP as outlined in Section 3.14.7 of RFP 3425 annually. As the vendor is the only DBA in the market the materials are more educational than marketing; however, all material is submitted to the division and reviewed for approval.
3. The vendor may submit marketing materials for distribution during any open enrollment period.
4.

The DBA specialist will review marketing materials for open enrollment distribution periods and approve materials that meet federal and state requirements. The vendor is the singular dental PAHP provider and therefore does not typically submit marketing materials as it is defined in 42 CFR §438.104.

3. *Secret Shopper Survey:*

1. The responsible party is the DHCFP DBA Specialist.
2. The vendor is required to conduct a secret shopper survey annually to verify appointment wait times are within acceptable limits. The vendor is also required to present on their findings once per year at a quarterly quality meeting held by the DHCFP.
3. Annually, the DBA vendor will present on its Secret Shopper findings.

4. If the DHCFP DBA Specialist identifies timely access issues from the presentation, then the specialist is responsible to follow up with the vendor to ensure that quality improvement plans have been put in place. If it is determined that the plan did not elect to make improvements as a result of the secret shopper, then the DHCFP DBA Specialist will follow up on contract non-compliance issues and address them with a corrective action plan.

## 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: a. Other: The contract requires the vendor be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor.

Confirmation it was conducted as described:

X___ Yes

___ No. Please explain: N/A

Summary of results: The DBA is accredited by URAC® - Dental Plan, 7.3 Accreditation Program as a Medicaid, Health Maintenance Organization, Nevada and Medicaid, Exclusive Provider Organization, Nevada. The DBA provided a certificate of award as well as a summary of the accreditation results to DHCFP. DHCFP's dental program specialist reviewed the report which included a URAC® committee determination of

"Full Accreditation" and an achievement score of 100%. All core requirements were met. The accreditation is effective from July 1, 2019 through July 1, 2022
Problems identified: None
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: b. Same as strategy a. above

Strategy: d. Data Analysis (non-claims)
Grievances and appeals data from the contracted vendor quarterly PCP termination rates and reasons
Confirmation it was conducted as described:
X Yes
___ No. Please explain: N/A
Summary of results: The DBA submitted Enrollee Grievance, Enrollee Appeal Resolution, Provider Dispute Resolution, and Notice of Action reports to DHCFP's Hearings Unit as requested and listed in DHCFP's frequency report document. Additionally, the DBA provided monthly Provider Termination Reports to DHCFP's program integrity unit. These reports were reviewed by the Hearings Unit and Program Integrity staff to identify patterns that could create potential issues.
Problems identified: N/A
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: d. Other: The DBA submits the following reports: program integrity reports, reports on services provided, and dispute resolution reports. Reports and data are submitted to the state monthly, quarterly, and on an annual basis.
Confirmation it was conducted as described:
X__ Yes
___ No. Please explain: N/A
Summary of results: As directed by DHCFP, the DBA submitted the following program integrity reports: Dental Report – Patient; Dental Report – Provider; Dental Report - Service Counts and Costs; and Provider Dispute Resolution. The review and analysis of these reports by the respective program units did not identify any issues or concerns.
Problems identified: N/A.
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: g. Geographic mapping of provider network
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain: N/A
Summary of results: The DBA submitted monthly geo access mapping reports to the State as requested. DHCFP's dental program specialist reviewed these reports which include an accessibility summary of general dentists and specialists within the network in relationship to where members reside.

Problems identified: No problems were identified.
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: h. Independent Assessment of program impact, access, quality, and cost-effectiveness
Confirmation it was conducted as described:
X___ Yes
___ No. Please explain: N/A
Summary of results: DHCFP elected to utilize the subcontracted EQRO to complete the program impact, access, and quality portions of the federally required independent assessment activities. DHCFP contracted with a separate vendor to complete the cost effectiveness portion of the independent assessment. Both entities were required to work collaboratively with the DHCFP and the DBA. DHCFP utilized the independent assessment results to move forward with a renewal application.
Problems identified: The independent assessment was not completed 90 days prior to the end of the waiver period. Consequently, in November 2019, DHCFP requested a 3-month temporary extension to its 1915 (b) waiver to allow additional time to complete the assessment. The request was granted on November 18, 2019. The independent assessment was submitted along with the waiver renewal application on December 23, 2019 with an effective date of April 1, 2020. The DHCFP again utilized the EQRO to complete the program impact, access, and quality portions of the federally required independent assessment activities. DHCFP contracted with a separate vendor to complete the cost effectiveness portion of the independent assessment. Both entities were required to work collaboratively with the DHCFP and the DBA for the period between April 2020 through June 2021, and will be submitted with this waiver renewal application.
Corrective action (plan/provider level) N/A
Program change (system-wide level) DHCFP developed a waiver application timeline to ensure that waiver renewal applications and associated independent assessments are submitted timely.

Strategy: j. The DBA must maintain an adequate network of providers.
Confirmation it was conducted as described:
___X Yes
___ No. Please explain: N/A
Summary of results: The DBA submitted monthly GEO Access reports and quarterly Network Adequacy reports in addition to monthly provider count reports. DHCFP's dental program specialist monitored monthly GEO Access reports to determine that, at a minimum, pediatric dentists, dental hygienists, and oral surgeons in each geographic service area were sufficient to provide necessary access to care. The DBA met DHCFP's standard of member access to at least two (2) specialists in their service areas. Time and distance standards (30 minutes/20 miles), established by DHCFP for general dentists and pediatric dentists, were also consistently met. For example, in CY 2020, 99.9% of adult members in Clark County and 99.8% in Washoe County fell within these standard. For children, the rate was 99.9% in both counties.

In addition, the dental program specialist analyzed quarterly Network Adequacy reports to confirm the availability of at least one full-time equivalent (FTE) dentist per 1,500 recipients per geographic service area. Throughout the waiver period, the DBA consistently exceeded this provider-to-member ratio established by DHCFP for primary care dentists.
Problems identified: N/A
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: l. On-site review
Confirmation it was conducted as described:
___X Yes
___ No. Please explain: N/A
Summary of results: Annual compliance reviews, which included on-site reviews, were held as planned. However, during the COVID -19 pandemic, the on-site review was conducted virtually through a Webex session. The DHCFP and the contracted EQRO reviewed specific standards each year of the 3-year review period. After each review, the EQRO provided a comprehensive report to DHCFP. The review for SFY 2018-19 focused on requirements for member services and experiences and the EQRO provided a report to DHCFP in November 2019. The DBA received a composite score of 94.1 percent for all elements evaluated and the DBA demonstrated average compliance with federal and State requirements. The review for 2019-2020 focused on managed care operations and was provided to DHCFP in October 2020. The DBA had an overall composite score of 96 percent for all elements evaluated. The EQRO determined that based on the findings of the review, the DBA "demonstrated strong compliance with the federal and State requirements contained in its managed care contract."
Problems identified: N/A
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: t. Other: *Member Handbook*
Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain: N/A
Summary of results: The compliance review for SFY 2018-19 included a review of member services and experiences with a focus on member rights and responsibilities, member information, continuity and coordination of care, grievances and appeals, and coverage and authorization services. As a result, the DBA's member handbook was reviewed. In addition to how to choose a dental home/provider and how to change the dental home/provider, DHCFP identified 24 specific topics to be included, at a minimum, in the member handbook. The DBA made several revisions which were reviewed by the dental program specialist to ensure the handbook provides required, detailed information to members. Since then, the DBA submitted drafts of proposed changes when updates were made and on an annual basis. The dental program specialist reviewed and approved each revision to confirm contract compliance.
Problems identified: N/A

Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: t. Other: *Marketing*
Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain: N/A
Summary of results: The DBA is the singular dental PAHP provider and therefore does not typically submit marketing materials as it is defined in 42 CFR §438.104. However, the DBA submitted general communications and outreach material such as brochures, flyers for special events, member forms, scripts for text messages, and general communications to members for review and approval to the dental program specialist as documented by email correspondence. In addition to reviewing the content of material, the dental program specialist checked documents for readability at the eight-grade reading level as required by the contract.
Problems identified: N/A
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

Strategy: t. Other: *Secret Shopper Survey*
Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain: N/A
Summary of results: To ensure appropriate access and availability standards are met and to identify opportunities for process improvements, the DBA's member services department conducted secret shopper surveys and provided activity report summaries to DHCFP 90 days after CY end date as directed. For the most recent report, the DBA analyzed access and availability data for emergency services, urgent care, routine services, preventive care, specialist emergency services, specialist urgent care and specialist routine care. The DBA attempted to contact 271 offices; 12 offices could not be reached. (Please note, during the survey period, offices had reduced hours, closed temporarily or only accepted emergency appointment due to COVID-19.) The DBA found that four offices did not meet established standards. DHCFP's dental program specialist reviewed the summary report and determined that quality improvements were initiated by the DBA network manager who contacted all four offices to provide counseling and will monitor future compliance.
Problems identified: N/A
Corrective action (plan/provider level) N/A
Program change (system-wide level) N/A

# 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: Phillip Burrell

a. Telephone Number: (775) 684-3699

d. E-mail: pburrell@dhcfp.nv.gov

e. The State is choosing to report waiver expenditures based on

_X_ date of payment.

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

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

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

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

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

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

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

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

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

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

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

a.___ MCO
b.___ PIHP
c._X_ PAHP
d.___ Other (please explain):

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

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

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

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

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

## E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.__ 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: None.

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

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

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

For Conversion or Renewal Waivers:

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

b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. R2 reflects data for January 2021 through June 2021. 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: Projections take into account historical data, economic conditions, and population growth.

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

e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: R1 reflects April 2020 through December 2020. R2 reflects January 2021 through December 2021, with complete data through June 2021.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: No different services.

b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: No excluded services.

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

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

For Initial Waivers:

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

| **Additional Administration Expense** | **Savings projected in State Plan Services** | **Inflation projected** | **Amount projected to be spent in Prospective Period** |
|---|---|---|---|
| ***N/A*** | ***N/A*** | ***N/A*** | ***N/A*** |
| | | | |
| | | | |
| | | | |
| 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. X The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.* Administrative costs are allocated based upon the program cost as a percentage of the total service costs. For each MEG, the actual dental costs for MCO dental waiver clients is divided by the medical costs for that MEG to determine the ratio to apply to the administrative costs. Note that the CHIP administrative costs are used for the CHIP to Medicaid MEG and the Medicaid administrative costs are used for the calculation of administrative costs for the other MEGs.

c.___ Other (Please explain).

**H. Appendix D3 – Actual Waiver Cost**

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

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

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

| 1915(b)(3) Service | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *N/A* | *N/A* | *N/A* | *N/A* |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| Total | *(PMPM in Appendix D5 Column T x projected member months should correspond)* | | **(PMPM in Appendix D5 Column W x projected member months should correspond)** |

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

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

| 1915(b)(3) Service | Amount Spent in Retrospective Period | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| ***N/A*** | ***N/A*** | ***N/A*** | ***N/A*** |
| | | | |
| | | | |
| | | | |
| **Total** | **(PMPM in Appendix D3 Column H x member months should correspond)** | | **(PMPM in Appendix D5 Column W x projected member months should correspond)** |

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

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

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

i. Document the criteria for awarding the incentive payments.

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

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

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service

incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

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

**Current Initial Waiver Adjustments in the preprint**

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

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

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

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

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

2. __ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated 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: The Consumer Price Index (CPI) for Medical Care Services is used as the State Plan Adjustment Factor. 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**.

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

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

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

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while

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

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

2. 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. ____ 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. X 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. The CPI for Medical Care Services is used as the administrative cost adjustment trend. The CPI for Medical Care Services measures the increase in the cost of medical care services over time. This growth rate is applied to the base period administrative costs, which include both managed care and fee-for-service costs. The projection of the CPI for Medical Care Services is from Moody's Economy.com. The projected CPI for CY2022 of 3.6% is used as the administrative cost adjustment for prospective year one and the projected CPI for CY2023 of 3.9% is used for prospective year two.

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

reflects the changes in utilization between R2 and P1 and between years P1 and P2.

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

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

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

Others:

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

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

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

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

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

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

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

***D.____Determine adjustment for Medicare Part D dual eligibles.***

E.____X Other (please describe): Two program adjustments were used in prospective year 1. (1) In 31st Special Session of the Nevada legislature, Assembly Bill 3 (AB3) was passed. This bill required 6% rate reductions for all providers paid through a fee schedule, including dental providers. This 6% cut was reflected in the calendar year 2021 dental capitation rates. These rate cuts were submitted to CMS for review but have not been approved. During the 81st Legislative Session, the legislature approved a retroactive elimination of the rate reductions that were not yet approved by CMS. The state's actuary is revising the calendar year 2021 dental capitation rates to reflect this elimination of the rate reduction. After the revised dental capitation rates are certified, the state will may payments to the dental benefits administrator to reflect this retroactive increase in capitation rates. This payout is anticipated to occur later in calendar year 2021 and is not currently reflected in the R2 expenditures. (2) Actual data for R2 is available only through the quarter ending June 30, 2021. Because of the timing of the fiscal agent's provider run, only two "capitation runs" were included in the R2 Q2 data for 3243-11 CHIP to Medicaid and 3243-12 Parents and Children. In other words, we expected there to be 6 capitation runs for these MEGs during the first two quarters of R2, but there were only 5. Therefore, we included a program adjustment of 20% to reflect that the costs for these categories for R2 year to date were understated by approximately 20%. This adjustment does not apply to the 3243-13 Newly Eligible MEG.

***F.____***

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.___ 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): The CPI for Medical Care Services is used as the administrative cost adjustment trend. The CPI for Medical Care Services measures the increase in the cost of medical care services over time. This growth rate is applied to the base period administrative costs, which include both managed care and fee-for-service costs. The projection for the CPI for Medical Care Services is from Moody's Economy.com. The projected CPI for CY2022 of 3.6% is used as the administrative cost adjustment for prospective year one and the projected CPI for CY2023 of 3.9% is used for prospective year two.

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

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

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program

(P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

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

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

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

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

ii. State Plan Service Trend

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

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

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

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

_____

**3.** Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the

supplemental payment does not matter for the purposes of this analysis.

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

*Basis and Method:*

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

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

3.___ Other (please describe):

1.___ No adjustment was made.

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

## K. Appendix D5 – Waiver Cost Projection

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

## L. Appendix D6 – RO Targets

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

## M. Appendix D7 - Summary

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

The CPI projections are slightly lower in prospective years one and two than in the prior waiver period. The CPI for Medical Care Services measures the increase in the cost of medical care services over time. This growth rate is applied to the retrospective period administrative costs, which include both managed care and fee-for-service costs. The CPI for CY2022 of 3.6% is used as the administrative cost adjustment for prospective year one and the CPI for CY2023 of 3.94.0% is used for prospective year two. In the prior period, the CPI for CY2020 of 4.8% and the CPI for CY2021 of 4.0% were used.

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**: Projections take into account historical data, economic conditions, and population growth.

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**: The CPI for Medical Care Services is a nationwide measure of the inflation related to medical services and is appropriate to use in these calculations because state specific trend data is not readily available for these services. This measure reflects only price increases and not changes in utilization. Moody's Economy.com projections are used for the CPI for Medical Care Services. The projected CPI for CY2022 of 3.6% is used as the administrative cost adjustment for prospective year one and the projected CPI for CY2023 of 3.9% is used for prospective year two.

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

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

## Part II: Appendices D.1-7

Please see attached Excel spreadsheets.