

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



**Florida Medicaid
Non-Emergency Transportation Waiver
(NET)**

Waiver Renewal

**Effective Dates: 4/1/2023 – 3/31/2025
Submission Date: March XX, 2023**



**US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations**

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Facesheet

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

The **State of Florida** requests a waiver/renewal under the authority of section 1915(b) of the Social Security Act, herein referred to as 'the Act'. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Non-Emergency Transportation. (Please list each program name if the waiver authorizes more than one program.).

TYPE OF REQUEST

Initial request for new waiver. All sections are filled.

Amendment request for existing waiver, which modifies Section/Part ____
 Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
 Document is replaced in full, with changes highlighted

Renewal request

This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

The State has used this waiver format for its previous waiver period.

Section A is:

replaced in full

carried over from previous waiver period. The State:

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

assures the same Program Description from the previous waiver period will be used, with exceptions noted in attached replacement pages. **(The entire section has been included with selection changes highlighted.)**

Section B is: replaced in full

carried over from previous waiver period. The State:

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

assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages. **(The entire section has been included with selection changes highlighted.)**

EFFECTIVE DATES

This waiver/renewal/amendment is requested for a period of 2 years; effective 4/1/2023 and ending 3/31/2025. (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 Catherine McGrath and can be reached by telephone at (850) 412-4256, or e-mail at Catherine.McGrath@ahca.myflorida.com(Please list for each program)

Section A: Waiver Program Description

PART I: PROGRAM OVERVIEW

Tribal consultation

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

The State notified the two Tribal Organizations in the State of Florida prior to submitting this waiver renewal request. See **Attachment I** for tribal letters, e-mailed on February 24, 2023. This notification provided the Tribal Organizations with an opportunity to obtain additional information on Florida's Non-Emergency Transportation (NET) program or to provide comments regarding the renewal of the NET waiver proposal.

Program History, Description, and Services

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).

The State submitted a 1915(b)(4) NET Waiver application to the Centers for Medicare & Medicaid Services (CMS) on June 30, 2014 and received approval on December 17, 2014 for the period January 1, 2015 – December 31, 2016. The purpose of this waiver is to allow the Agency for Health Care Administration (Agency) to contract with one or more vendors to provide NET services to Florida Medicaid recipients not enrolled in Florida's Statewide Medicaid Managed Care (SMMC) program. The State submitted a renewal application to CMS on September 30, 2016. A temporary extension was approved for the period of January 1, 2017 – January 31, 2017, and the State received approval from CMS on January 11, 2017 for the period February 1, 2017 – January 31, 2019. The State submitted a renewal application to CMS on November 16, 2018 and CMS granted the renewal on January 24, 2019 for the period of February 1, 2019- January 31, 2021. The State submitted a renewal application to CMS on November 3, 2020 and CMS granted the renewal on January 05, 2021 for the period of April 1, 2021 – March 31, 2023.

Currently, the Agency contracts with two vendors to provide statewide coordination and oversight of Florida Medicaid NET services. The two contracted NET vendors, referred to as CNET plans, are paid a capitated amount based on a per-member per-month (PMPM) reimbursement methodology for eligible recipients.

The CNET plans have the option to provide services directly or subcontract for services. The current CNET plans are responsible for centralized call intake, eligibility determination, authorization of trips, scheduling and dispatching trips, and monitoring transportation providers.

The State assures CMS that it will comply 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. In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The Agency has met this requirement and has complied with the number of assessments needed.

A. STATUTORY AUTHORITY

1. Waiver Authority.

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

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **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. **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
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond

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

___ FFS Selective Contracting program (please describe)

2. Sections Waived.

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

- a. ___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. ___ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for 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)

(2) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis.

The PIHP is paid on a non-risk basis.

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

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

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

- e. **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

the same as stipulated in the state plan

is different than stipulated in the state plan (please describe)

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

2. Procurement.

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

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)

The CNET plans were procured under the authority of Section 287.057(3)(e)7, Florida Statutes (F.S.), which allows the Agency to selectively contract with qualified vendors providing health care related services without going through the competitive procurement process.

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.

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

2. Details.

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

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

The State is currently contracted with two vendors. Each CNET plan serves different regions of the State; see chart on the following page.

3. Rural Exception.

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

4. 1915(b)(4) Selective Contracting

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

D. GEOGRAPHIC AREAS SERVED BY THE WAIVER

1. General.

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

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

2. Details.

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1	PAHP	Modivcare.
Region 2	PAHP	Modivcare
Region 3	PAHP	Medical Transportation Management, Inc.
Region 4	PAHP	Medical Transportation Management, Inc
Region 5	PAHP	Medical Transportation Management, Inc
Region 6	PAHP	Medical Transportation Management, Inc
Region 7	PAHP	Medical Transportation Management, Inc
Region 8	PAHP	Medical Transportation Management, Inc
Region 9	PAHP	Modivcare
Region 10	PAHP	Modivcare
Region 11	PAHP	Modivcare

E. POPULATIONS INCLUDED IN WAIVER

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

1. Included Populations.

The following populations are included in the Waiver Program:

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

- ___ Mandatory enrollment

- ___ Voluntary enrollment

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

- ___ Mandatory enrollment

- ___ Voluntary enrollment

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

Other – Please Describe:

Florida Medicaid recipients who are excluded from enrollment in Florida’s Managed Medical Assistance (MMA) program:

- Women who are enrolled through the Breast and Cervical Cancer program
- Presumptively eligible pregnant woman
- Recipients receiving services through the Medically Needy program.

Florida Medicaid recipients who are voluntary for enrollment in Florida’s MMA program, and have chosen not to enroll in an MMA plan:

- Recipients who have other credible health care coverage, excluding Medicare
- Recipients enrolled in the developmental disabilities home and community-based services waiver, pursuant to Chapter 393 Florida Statutes, and recipients on the waiting list for these waiver services
- Children receiving services in a prescribed pediatric extended care center
- Recipients residing in a group home facility licensed under Chapter 393, Florida Statutes.

2. Excluded Populations.

Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population

may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

- Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- Other Insurance**--Medicaid beneficiaries who have other health insurance.
- 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.
- 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.

Other (Please define):
Florida Medicaid recipients who:

- Are mandatory for enrollment in Florida’s MMA program and are enrolled in an MMA plan
- Are qualified Medicare Recipients, Specified Low Income Medicare Recipients, Qualified Medicare Recipients Renal Dialysis

Florida Medicaid recipients who reside in an institution, including:

- Statewide inpatient psychiatric program facilities
- Intermediate care facility for individuals with intellectual disabilities
- State Hospitals
- Correctional institutions

Florida Medicaid recipients who reside in the following:

- Residential commitment programs/facilities operated through the Department of Juvenile Justice
- Residential group care operated by the Family Safety & Preservation Program of the Department of Children & Families (DCF)
- Children's residential treatment facilities purchased through the Substance Abuse & Mental Health (SAMH) District Offices of the DCF (also referred to as Purchased Residential Treatment Services)
- SAMH residential treatment facilities licensed as Level I and Level II facilities
- Residential Level I and Level II substance abuse treatment program

Florida Medicaid recipients eligible for emergency services only due to immigration status

Florida Medicaid recipients enrolled in the Family Planning Waiver

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.

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).

This program does not provide emergency services or family planning services. This program provides NET services only.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family

Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

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

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

2. Emergency Services.

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

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

3. Family Planning Services.

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

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

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

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

Other (please explain):

Family planning services are not included under the waiver.

4. FQHC Services.

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

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

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

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

FQHC services are not included under the waiver.

5. EPSDT Requirements.

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:

The NET program does not require recipients obtain prior authorization to access services. However, recipients are screened in order to provide the most medically appropriate and cost effective mode of transportation.

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.

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

B. CAPACITY STANDARDS

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

- The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

The following tables represent the vendor capacity for the CNET plans.

**Table 1: 2022 Capacity Analysis
Medical Transportation Management, Inc.**

County	2022 Total Ambulatory Vehicles	2022 Wheelchair Vehicles	2022 Stretcher Vehicles
Alachua	38	53	1
Baker	41	65	1
Bay	0	0	1
Bradford	39	53	1
Brevard	39	21	1
Broward	15	6	2
Calhoun	2	10	0
Charlotte	4	5	0
Citrus	0	0	1
Clay	39	53	1
Collier	26	25	1
Columbia	35	39	2
Desoto	8	6	1
Dixie	14	30	1
Duval	28	41	5
Escambia	2	2	0
Flagler	23	23	0
Franklin	0	0	0
Gadsden	0	0	0
Gilchrist	26	36	0
Glades	0	0	0
Gulf	0	0	0
Hamilton	10	6	0
Hardee	12	12	0
Hendry	0	0	0
Hernando	16	7	0
Highlands	27	20	1
Hillsborough	49	35	4
Holmes	0	0	2
Indian River	20	12	2
Jackson	0	0	0
Jefferson	0	0	0
Lafayette	26	36	0
Lake	27	15	2

Lee	39	33	0
Leon	9	3	3
Levy	4	24	0
Liberty	0	0	0
Madison	10	6	0
Manatee	7	2	0
Marion	16	5	4
Martin	17	9	1
Miami-Dade	43	38	7
Monroe	6	11	6
Nassau	21	9	0
Okaloosa	2	2	0
Okeechobee	15	8	1
Orange	54	49	6
Osceola	54	30	0
Palm Beach	17	9	1
Pasco	28	19	26
Pinellas	55	43	2
Polk	39	23	2
Putnam	35	29	0
St. Johns	21	9	0
St. Lucie	17	9	3
Santa Rosa	11	5	0
Sarasota	7	2	0
Seminole	33	20	0
Sumter	0	0	0
Suwannee	14	30	1
Taylor	10	6	0
Union	16	30	0
Volusia	16	8	2
Wakulla	0	0	0
Walton	2	2	0
Washington	0	0	0
Total	1184	1084	95

Table 2: 2022 Capacity Analysis
Modivcare Solutions, LLC

Table 2: 2022 Capacity Analysis Modivcare Solutions, Inc.				
TP County	2022 Ambulatory Vehicles	2022 Wheelchair Vehicles	2022 Stretcher Vehicles	2022 Total Vehicles
ALACHUA*	23	3		26
BAKER*	5	2		7
BREVARD*	7	2	1	10
BROWARD*	20	13	1	34
CALHOUN	80	28	4	112
CITRUS*		1	4	5
CLAY*	11	11		22
COLLIER*	5			5
COLUMBIA*	1	8	4	13
DADE	695	56	8	759
ESCAMBIA	6	2		8
FLAGLER*	5			5
HENDRY*	5			5
HIGHLANDS*	5		2	7
HILLSBOROUGH*	72	15	2	89
JEFFERSON	4	1		5
LAKE*	5	4	1	10
LEE*	12	4		16
LEON	7	64		71
MANATEE*	1			1
MARION*	9	1		10
NASSAU *	1			1
OKALOOSA		4		4
ORANGE*	108	33	4	145
OSCEOLA*	22			22
PALM BEACH	31	6	1	38
PASCO*	8	5	4	17
PINELLAS*	4	4		8
POLK*	4	3	4	11
ST LUCIE		1		1
SANTA ROSA		1		1
SARASOTA *	12	8		20
SEMINOLE*	23		2	25
ST LUCIE	3	3	1	7
ST. JOHNS*	2	7		9

SUWANNEE*	4	5		9
VOLUSIA*	8	2		10
WAKULLA	1	4		5
BAY	1			1
Grand Total	1,210	301	43	1,554

C. COORDINATION AND CONTINUITY OF CARE STANDARDS

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

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

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

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

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

The following items are required.

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

The CNET plans must ensure NET services meet the medical needs of its recipients including use of multi-load vehicles, public transportation, wheelchair vehicles, stretcher vehicles, private volunteer transport, over-the-road bus services, or, where applicable, commercial air carrier transport and non-emergency ambulance transport.

The CNET plans must allow for one escort when, due to age or disability, a recipient needs the accompaniment and support of another individual to be able to travel to receive necessary medical services.

b. ___ **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

- c. ___ **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
- d. ___ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
 1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. ___ In accord with any applicable State quality assurance and utilization review standards.
- e. ___ **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. Details for 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.

The CNET plans must maintain contracts with a sufficient number of providers to ensure that NET services are provided promptly and are reasonably accessible. The CNET plans are responsible for providing the most medically appropriate mode of transportation for the recipient's needs. If a CNET plan is unable to provide services to a recipient through its existing network of providers, the CNET plan must cover these services in an adequate and timely manner by using providers that are outside of the CNET plans' network.

The CNET plans must notify the Agency of any changes to the provider network that may impede recipients from accessing services in a timely manner. Significant changes in the network composition the Agency determines negatively impact recipient's access to services may be grounds for contract termination.

If recipients have difficulty with a transportation provider, he or she can report the provider to the CNET plans. Recipients are provided contact information for the CNET plans' call center in the recipient handbook. The recipient can also contact the Agency's central complaint hub.

The CNET plans are required to provide new recipients with a copy of the recipient handbook. The handbook must include, at a minimum, the following information:

- Vendor's toll-free trip scheduling telephone number,
- Time frames for requesting and receiving transportation services,
- Information on after hours, urgent care and emergency transportation requirements,
- Medicaid recipient's rights and responsibilities,
- Information regarding the availability of alternative communication formats,

- Complaints, grievances and appeals process, and
- Information regarding the vendor’s “no-show” policy.

PART III: QUALITY

1. Assurances For PAHP program.

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

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

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

2. Details for 1915(b)(4) only programs:

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

The CNET plans were procured under the authority of Section 287.057(3)(e)7, Florida Statutes (F.S.), which allows the Agency to selectively contract with qualified vendors providing health care related services without going through the competitive procurement process. The Agency assessed whether the potential contractors met all of the following criteria:

1. Experience in and or knowledge of the provision of providing NET to eligible recipients.
2. Adequate staffing requirements.
3. Adequate program coverage capacity for regions or statewide.
4. Able to determine recipient’s eligibility for NET services and the type of service needed.
5. Able to maintain a sufficient network of transportation providers (either directly through its own network of transportation providers or through a provider contract relationship).
6. Ensure compliance with all applicable federal and state regulations, including the Americans with Disabilities Act requirements, vehicle and equipment safety standards, etc.
7. Compliance with encounter data submission requirements.
8. Utilization monitoring and reporting.
9. Procedures for providing transportation services outside of a region.

10. Able to develop and implement a timeline for a sufficient transportation network and system and to coordinate, deliver, monitor and track all NET services.
11. Able to describe their current network requirements, including vehicle descriptions, to best deliver the services.
12. Ability to process timely payment of claims.
13. Able to maintain and monitor a specialized complaint system.
14. Able to provide an estimate of cost to provide the NET to members based on a per-member, per-month basis.

The CNET plans must comply with the following performance standards:

1. At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.
2. The average speed of call answer shall not exceed forty-five (45) seconds.
3. The call blockage rate for direct calls to the vendor shall not exceed one percent (1%).
4. The average call abandonment rate for direct calls to the vendor shall not exceed five percent (5%).
5. At least ninety-five percent (95%) of service authorizations are processed within the timeframes specified in the contract.

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

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

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

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

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

This waiver is for a 1915(b)(4) Selective Contracting Program.

2. Details

a. Scope of Marketing

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. 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.

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

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

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the

Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

2. Details

a. Non-English Languages

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 5 percent or more of the potential enrollee/ enrollee population.
3. Other (please explain):

Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

The CNET plans must provide oral translation services to any recipient who speaks any non-English language regardless of whether the recipient speaks a language that meets the threshold of a prevalent non-English language.

The CNET plans must notify recipients of the availability of oral interpretation services and how to access them. The CNET plans must ensure oral interpretation services are available to recipients for all information provided, including notices of adverse action.

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

The CNET plans must notify recipients in writing of their rights and responsibilities; how to obtain routine transportation services; how to obtain transportation in an emergency or urgent care situation; how to file a complaint, grievance, appeal, or Medicaid fair hearing; and how to report suspected fraud and abuse.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

State

Contractor (please specify)

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

The State offers assistance to recipients on how to access NET services in their region. The CNET plans must mail or hand-deliver a recipient handbook to all eligible individuals.

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) the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

The CNET plans must mail or hand-deliver a recipient handbook to all eligible individuals.

C. ENROLLMENT AND DISENROLLMENT

1. Assurances.

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

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

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

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

2. Details.

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

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

b. Administration of Enrollment Process.

State staff conducts the enrollment process.

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

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

Broker name: _____

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

- State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.
The State automatically enrolls all eligible recipients into the CNET plan in his or her region.

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.

The State **automatically enrolls** beneficiaries

on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

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

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

— The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

___ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- i. ___ Enrollee submits request to State.
- ii. ___ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

X 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.

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

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

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

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

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

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

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.

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

2. Optional grievance systems for PCCM and PAHP programs.

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

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

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

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

Any expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality and timeliness of services provided and aspects of interpersonal relationships such as unprofessional behavior or failure to respect a recipient's rights.

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

Specifies a time frame from the date of action for the enrollee to file a request for review, which is: 1 year (please specify for each type of request for review)

Has time frames for resolving requests for review. Specify the time period set: 30 days (please specify for each type of request for review)

Establishes and maintains an expedited review process for the following reasons: request of recipient. Specify the time frame set by the State for this process.

The vendor has 3 days to resolve an expedited review unless recipient's condition requires a specific timeframe.

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

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

___ Other (please explain):

F. PROGRAM INTEGRITY

1. Assurances.

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

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity; 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.

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.

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)).

PART 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.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data												
Data Analysis (non-claims)						X						
Enrollee Hotlines					X	X	X	X				X
Focused Studies												
Geographic mapping												
Independent Assessment						X	X			X		X
Network Adequacy Assurance by Plan							X			X		
On-Site Review												
Performance Improvement Projects												
Performance Measures							X					
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other:	X	X	X	X	X	X	X		X	X		X

PART II: DETAILS OF MONITORING ACTIVITIES

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

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

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

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

- NCQA
- JCAHO
- AAAHC
- Other

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

- NCQA
- JCAHO
- AAAHC
- Other

c. Consumer Self-Report data

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

d. Data Analysis (non-claims)

- Denials of referral requests
- Disenrollment requests by enrollee
- From plan
- From PCP within plan
- Grievances and appeals data
- PCP termination rates and reasons
- Other (please describe)

The CNET plans must submit monthly summary reports, which cover all complaints, grievances and appeals data related to NET to the Agency for review. Grievances and appeals data is also reviewed, as applicable, during on-site reviews for each vendor. Daily calls, scheduled calls, and ad hoc calls take place with each vendor to ensure compliance and complaint resolution.

e. Enrollee Hotlines operated by State

The CNET plans must operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking recipients. The CNET plans may use an automated telephone triage system. The toll-free help line shall respond to all areas of recipient and provider inquiries.

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. Geographic mapping of provider network

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

In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The results from the most recent independent assessment have been included as Attachment II. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

i. Measurement of any disparities by racial or ethnic groups

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

- The CNET plans are responsible for the administration and management of a transportation provider network.
- The Agency must be notified prior to the effective date of the non-renewal, suspension, termination, or withdrawal of a provider from the transportation provider network.
- The CNET plans must provide lists of subcontractors to the Agency by October 1 of every year.

k. Ombudsman

l. On-site review

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

- At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.
 - The average speed of call answer shall not exceed forty-five (45) seconds.
 - The call blockage rate for direct calls to the CNET plan shall not exceed one percent (1%).
 - The average call abandonment rate for direct calls to the CNET plan shall not exceed five percent (5%)
 - At least ninety percent (90%) of service authorizations are processed within the timeframes specified in the contract.
- 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)

Marketing – The State does not permit marketing under the contract with the CNET plans. The CNET plans receive monthly eligibility information which outlines those recipients eligible to receive NET.

Enrollment/Disenrollment - Recipients are automatically assigned to a CNET plan based upon the region in which he or she resides. If a recipient is voluntary for enrollment in an MMA plan, the recipient may choose to enroll in an MMA plan upon which the recipient would be disenrolled from the NET waiver.

Coordination/Continuity - Recipients do not receive treatment from the CNET plans. The CNET plans must ensure NET services are provided to all assigned eligible recipients.

Coverage/Authorization - NET services are scheduled in advance and are not prior authorized.

Desk Reviews - The Agency performs annual desk reviews to ensure the CNET plans are compliant with contract requirements. Desk reviews include assessment of the following:

- Recipient Services
- Grievance and Appeals
- Provider Services
- Performance Standards
- Encounter Data

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.

This is a renewal request.

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

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

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

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

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

1. **Strategy: Data Analysis (Non-Claims)**

Description: The CNET plans are required to submit monthly summary reports, which cover all complaints, grievances and appeals data related to NET to the Agency for review. Grievances and appeals data is also reviewed, as applicable, during on-site reviews for each vendor.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: To monitor the progress and performance of the contractual services, as specified in the vendor's contract, the Agency reviews monthly deliverables as provided by the vendors. Both vendors have been 100% timely and complete in submitting monthly deliverables to the Agency in years 2018, 2019, 2020, 2021 and 2022

The CNET plan's monthly deliverables address the following areas:

- Number of members utilizing transportation
- Trips set up with advance notice
- Trips with mileage in excess of 30 miles
- Service denials
- Trip utilization
- Trip mode (ambulatory, ambulance, and stretcher van)
- Call center timeliness
- Quality management
- Recipient complaints

Recipients have the option to submit their complaints directly to the CNET plan or to the Agency's Medicaid Complaint Operations Center. The Agency monitors all complaint sources, and the Agency addresses unresolved complaints on CNET plan operational calls until the complaint issues are resolved.

The Agency monitors all grievances and appeals relating to complaints that remain open and unresolved pursuant to the contractual guidelines.

In October of 2020, the Agency advised the CNET plans that they would be responsible for providing a grievances and appeals report to the Agency monthly. The Agency provided the reporting template with instructions to the vendors and spent considerable time reviewing reporting categories and expectations. The Agency met with the grievance and appeals coordinators for both plans. The report was implemented during the first quarter of 2021. The Agency receives the grievances and appeals reports monthly and reviews for adherence with CMS federal guidelines and Agency standards.

Problems identified: Yes

Corrective action (plan/provider level): Both plans were required to immediately remove any complaints that did not meet the criteria for grievances and appeals. Both plans were required to provide the Notice of Adverse Benefit Determination (NABD) and grievance letters to recipient complaints meeting criteria and to follow-up with plan appeals. Corrected information was updated and resubmitted to the Agency to ensure compliance.

Program change (system-wide level): None

2. Strategy: Enrollee Hotline

Description: The CNET plans must operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking recipients. The CNET plans may use an automated telephone triage system. The toll-free help line must respond to all areas of recipient and provider inquiries.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: The CNET plans have maintained an enrollee hotline and have met all contract requirements related to the enrollee hotline.

Problems identified: None

Corrective action (plan/provider level): None

Program change (system-wide level): None

3. Strategy: Network Adequacy

Description: The CNET plans are responsible for the administration and management of a transportation provider network. The Agency must be notified prior to the effective date of the non-renewal, suspension, termination, or withdrawal of a provider from the transportation provider network. The CNET plans must submit a Provider Termination and New Provider Notification Report by the fifteenth (15th) calendar day of the month following the reporting month.

Additionally, the CNET plans have numerous transportation modalities available for maintaining network adequacy. These include being able to use transportation network companies (ride sharing), starting in 2019. Others include private vehicles, taxis, public transportation, vans, ambulances, airlines, and non-profit agencies. Yearly, both CNET plans provide an updated Network Development Plan to the Agency for review. This year, both CNET plans completed a walk-through presentation to explain how they determine network adequacy for each of their assigned regions.

Confirmation it was conducted as described:

Yes

No. Please explain: .

Summary of results:

Problems identified: No

Corrective action (plan/provider level): None.

Program change (system-wide level): None

4. Strategy: On-site Review

Description: The Agency performs annual onsite contract monitoring reviews to ensure the CNET plans are compliant with the contract requirements.

Confirmation it was conducted as described:

Yes

No. Please explain: The Agency implemented remote monitoring to provide vendor oversight and ensure compliance as the on-site did not yield any additional information regarding performance.

Summary of results:

The Agency completed remote monitoring in 2021 and 2022. This remote monitoring evaluated the areas of complaints, claim submissions, encounter data accuracy, and provider network.

To date in 2022, the Agency has monitored vendors' compliance with Eligibility, Recipient Services, Grievance and Appeals, Provider Services, Performance Standards, Encounter Data, Timeliness and Utilization Management.

Complaints are received directly by the Agency or the CNET plan. The Agency monitors all complaints that come through the Medicaid Complaint Operations Center as well as escalated complaints that come through to the Agency CNET Contract Manager for assistance with resolution. Opened complaints are also discussed on operational calls until they are closed. See also Strategy #1 above on Data Analysis (Non-Claims).

Problems identified: Yes

Corrective action (plan/provider level): See Corrective action listed for Strategy #5

Remediated: Yes

Program change (system-wide level): None

5. Strategy: Performance Measures

Description: Performance threshold(s), requirement(s), or expectation(s) that must be met to be evaluated at a particular level of performance.

These performance measures include:

- At least 90% of recipients will arrive at their appointment at or before their scheduled appointment time.
- The average speed of calls answered shall not exceed 45 seconds.
- The call blockage rate for direct calls to the CNET plan shall not exceed 1%.
- The average call abandonment rate for direct calls to the CNET plan shall not exceed 5%.
- At least 95% of service authorizations are processed within the timeframes specified in the contract.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

New contracts went into effect in August 2019 and are effective through 2023.

The new contracts contain the following performance standards:

- At least ninety percent (90%) of recipients will arrive at their appointment within fifteen (15) minutes of the scheduled appointment time;
- The average speed of calls answered by vendors shall not exceed forty-five (45) seconds;
- The call blockage rate for direct calls to the CNET plans shall be less than one percent (1%);
- The average call abandonment rate for direct calls to the CNET plans shall not exceed five percent (5%); and
- More than ninety-five percent (95%) of service authorizations shall be processed by the vendors within the timeframes specified in the contract.

Both CNET plans have not successfully met these standards during the period of time since the new contract was executed.

Quarterly Call-Center Metrics Statewide Average Average Speed of Answer (in seconds) under 45 Seconds		
	MTM	Modivcare
7/2022-9/2022	23.52	0.09
4/2022-6/2022	14.15	0.14
1/2022-3/2022	10.42	0.09
10/2021-12/2021	6.68	0.20
7/2021-9/2021	9.00	0.29
4/2021-6/2021	3.03	0.36
1/2021-3/2021	5.63	0.08

Quarterly Call-Center Metrics Statewide Average 1% > Blocked Calls (in percent)		
	MTM	Modivcare
7/2022-9/2022	0%	0%
4/2022-6/2022	0%	0%
1/2022-3/2022	0%	0%
10/2021-12/2021	0%	0%
7/2021-9/2021	0%	0%
4/2021-6/2021	0%	0%
1/2021-3/2021	0%	0%

Quarterly Timeliness Goal of Report 90% of Recipients will arrive at their appointment within fifteen (15) minutes of the scheduled appointment time		
	MTM	Modivcare
7/2022-9/2022	98.99%	93.3%
4/2022-6/2022	98.11%	89.2%
1/2022-3/2022	97.06%	93.2%
10/2021-12/2021	96.0%	93.4%
7/2021-9/2021	97.88%	95.0%
4/2021-6/2021	97.13%	86.1%
1/2021-3/2021	96.75%	85.2%

Quarterly Call-Center Metrics Statewide Average 5% > Call Abandonment Rate (in percent)		
	MTM	Modivcare
7/2022-9/2022	1.55%	0.02%
4/2022-6/2022	0.79%	0.00%
1/2022-3/2022	0.48%	0.00%
10/2021-12/2021	0.39%	0.06%
7/2021-9/2021	0.75%	0.10%
4/2021-6/2021	0.34%	0.12%
1/2021-3/2021	0.75%	0.03%
10/2020-12/2020	1.47%	0.0%

Problems identified: MTM met overall timeliness standards. However, they fell short of the performance standard for recipients receiving Prescribed Pediatric Extended Care (PPEC) which was below 90% during the second quarter of 2021 and the second quarter of 2022. Modivcare did not meet overall timeliness standards during the first and second quarters of 2021 and the second quarter of 2022 for overall timeliness including PPEC. MTM and Modivcare both received corrective action plans. Most of the trips that arrived past their scheduled appointment time were associated with PPEC Services. Both plans experienced issues with how most PPECs set the “appointment time” as the time the transportation escort is to go out to pick up the member – not the time the member is scheduled to arrive at the PPEC facility. These trips are set as recurring - at the same time, for each day. PPECs operate on a “reservation”-basis meaning recipients do not have defined times by when they must arrive, unlike medical, behavioral, or dental appointments. This causes the timeliness reporting point to inaccurately reflect the timeliness of the recipient arrival. Recipients may have a variety of variables affecting times, such as medical appointments or school, and PPEC facilities do not update the schedules to reflect the daily fluctuations or new appointment times due to technology challenges, staffing and other required needs. Also, both MTM and Modivcare reported that they use claims data to compile their timeliness report. Both CNET Plans reported that recipients are still arriving to PPEC facilities to receive full PPEC services. The Agency has not received any complaints regarding PPEC recipients arriving late.

Corrective action (plan/provider level): As part of the corrective action plans both MTM and Modivcare were required to do extensive outreach to the PPEC facilities and report to the Agency on their efforts weekly. The Agency also required lag reports to show if the metric showed improvement overtime. Both CNET Plans are presently in compliance with timeliness.

Remediated: Yes

Program change (system-wide level): Yes, the appointment timeliness report is now due monthly but, on the thirtieth, (30) calendar day of the month following the reporting month instead of on the fifteenth calendar day. This will allow for more complete and accurate timeliness data. This change took place in August of 2022.

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 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 Medicaid Eligibility Group (MEG) in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
 Tom Wallace
 Telephone Number: 850-412-4117
 E-mail: Thomas.Wallace@ahca.myflorida.com
- c. 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. 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

For Initial Waivers only: Please mark all that apply.

- a. Population in the base year data
 - 1. Base year data is from the same population as to be included in the waiver.
 - 2. Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled

because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

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

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

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

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

For Conversion or Renewal Waivers:

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

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

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

Projected member months made for P1-P2 commenced from R2 (SFY22/23) population. We updated previous Projection year 1 for MEG 1 (PPEC) and MEG 2 (Non-PPEC) to actuals, and new member months utilization is 2/0%. The updated member months Projection for Year 2 on both MEG's is now 8.0%.

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

MEG1 (PPEC) PMPM Rates effective August 2022 have increased, and a 12.4% inflation adjustment factor has been applied to P1, see D5. Waiver Cost Projection tab.

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

Other Period - Waiver Renewal Period

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.____ [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**:

There are no other services included from the previous period.

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

There are no service exclusions from the cost-effectiveness analysis.

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
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

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

- a.____ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. Note: this is appropriate for MCO/PCCM programs
- b.____ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate

the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Note: this is appropriate for statewide PIHP/PAHP programs.

c. X Other (please Explain):

The cost of the one administrative full-time employee (FTE) is proportioned by each MEG's expenditure amount.

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
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		<i>(PMPM in Appendix D5 Column W x projected member months should correspond)</i>

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**

C1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	\$1,751,500 or \$.97 PMPM R1	8.6% or \$169,245	\$2,128,395 or 1.07 PMPM in P1
	\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion		\$2,291,216 or 1.10 PMPM in P2
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. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. X The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. ___ The State provides stop/loss protection (please describe):

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

1. ____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost)**. Regular State Plan service capitated adjustments would apply.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
2. ____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost)**. For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the Pre-Print

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 _____. 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 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. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the

current time period (*i.e., trending from 1999 to present*). The actual trend rate used is: **(See below)**. Please document how that trend was calculated.

The State reimburses the CNET plans via a yearly capitated PMPM payment. The rates were prepared by an actuary consultant. The rates used for cost effectiveness cover the time period of January 2019 through Dec 2023. through June 2020. The State is using these rates for this waiver’s Cost Effectiveness P1-P2 calculations.

In the table below, PPEC refers to recipients who receive prescribed pediatric extended care services.

COST EFFECTIVENESS P1-P2 PMPM CALCULATION										
	2019		2020		2021		2022		2023	
MEGs	Jan-Dec 2019	Jul 2018 – Jun 2019	Jan – Jul 2020	Jul 2019 – Jun 2020	Aug 2020 – Jul 2021	Jul 2020 – Jun 2021	Aug 2021 - Jul 2022	Jul 2021 – Jun 2022	Aug 2022 - Dec 2023	Jul 2022 – Jun 2023
PPEC	\$660.61	\$644.76	\$718.61	\$689.61	\$900.13	\$926.59	\$845.12	\$849.71	\$1,208.62	\$1,178.32
Non-PPEC	\$3.38	\$3.56	\$3.88	\$3.63	\$4.14	\$4.02	\$3.89	\$3.91	\$2.37	\$2.49

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 rate setting regulations) (*i.e., trending from present into the future*).

i. X State historical cost increases. Please indicate the years on which the rates are based:

Base years: WY1 (4/1/2021-3/31/2022) and WY2 (4/1/2022-3/31/2023).

For the quarter of 1/1/2023-3/31/2023 projections from last approved waiver were used.

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.

Please refer to the State’s response in a.1. above.

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.

Please refer to the State’s response in a.1. above.

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

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

Others:

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

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

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

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

For each change, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. Determine adjustment for Medicare Part D dual eligibles.
 - E. Other (please describe):
- ii. The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. Changes brought about by legal action (please describe):
For each change, please report the following:
- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. Other (please describe):
- v. Changes in legislation (please describe):
For each change, please report the following:
- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. Other (please describe):
- vi. Other (please describe):
- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

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

D. ___ X Other (please describe):

State applied for P1 PPEC inflation factor of 12.40% due to increases in capitation payments.

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

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

2. X An administrative adjustment was made.

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

ii. X Cost increases were accounted for.

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

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

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

D. X Other (please describe):

The State anticipates a general administrative FTE salary increase of 3% annually during P1-P2 for the single staff position assigned to this waiver's operation.

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.

The State reimburses the CNET plans via a yearly capitated PMPM payment. The rates were prepared by an actuary consultant. The rates used for cost effectiveness cover the time period of July 2016 through June 2020. The State is using these rates for this waiver’s Cost Effectiveness P1-P2 calculations.

In the table below, PPEC refers to recipients who receive prescribed pediatric extended care services.

COST EFFECTIVENESS P1-P2 PMPM CALCULATION										
	2019		2020		2021		2022		2023	
MEGs	Jan-Dec 2019	Jul 2028-Jun 2019	Jan-July 2020	July 2019-Jun 2020	Aug 2020-Jul 2021	Jul 2020-Jun 2021	Aug 2021-Jul 2022	Jul 2021-Jun 2022	Aug 2022-Dec 2023	Jul 2022-Jun 2023
PPEC	\$660.61	\$664.76	\$718.61	\$689.61	\$900.13	\$926.59	\$845.12	\$849.71	\$1208.62	\$1178.32
Non-PPEC	\$3.38	\$3.56	\$3.88	\$3.63	\$4.14	\$4.02	\$3.89	\$3.91	\$2.37	\$2.49

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.

Projected member months made for P1-P2 commenced from R2, Waiver Year 4/22-3/23 population.

P1: MEG 1 (PPEC) 12.40% and MEG 2 (Non-PPEC) a 5.3%.

P2: MEG 1 (PPEC) and MEG 2 (Non-PPEC) a 5.3% population growth rate.

M. Appendix D7 – Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

A 5% population growth rate calculated from both populations during SFY19/20 will yield an overall daily R1 to P2 weighted average PMPM case mix change of 0.01%, or 2.77% annually.
 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**:

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

The State reimburses the CNET plans via a capitated PMPM payment. Utilization used by Milliman in combination with adjustment cost in reflected in D.5 yields an annual rate of change for R1 to P2 of 13.68%.

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 the Excel spreadsheets.



NET Waiver Attachments

Attachment I	Tribal Letters
Attachment II	NET Waiver Excel Workbooks <i>(Included as a separate document)</i>

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Attachment I: Tribal Letters

Attachment II: Excel Workbooks

Submitted as separate documents.
