Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Texas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
MHREHAB	MHREHAB	FFS;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
MH Rehab

C. Type of Request. This is an:

☑ **Initial request for a new waiver.**

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 01/01/12

Requested Approval Period: *(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ◉ **2 years** ○ **3 years** ○ **4 years** ○ **5 years**

Draft ID: TX.58.00.00
Waiver Number: TX.0604.R00.00

D. Effective Dates: This waiver is requested for a period of 2 years. (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)
Proposed Effective Date: *(mm/dd/yy)*

01/01/12

Proposed End Date: 12/31/13
Calculated as "Proposed Effective Date" (above) plus two years minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Betsy Johnson

Phone: (512) 491-1199 **Ext:** ☐ **TTY**

Fax: (512) 491-1953

E-mail:

betsy.johnson@hhsc.state.tx.us

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **MHREHAB**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
The State provided notification to the Federally recognized tribes on December 3, 2010. The Federally recognized tribes were given 60 days for comments. No comments were received. Tribal letters and delivery confirmations will be sent to CMS via an email. Public notice was posted in the Texas Register on December 17, 2010.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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.
-- *Specify Program Instance(s) applicable to this authority*
☐ **MHREHAB**

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.
-- *Specify Program Instance(s) applicable to this authority*
☐ **MHREHAB**

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.
-- *Specify Program Instance(s) applicable to this authority*
☐ **MHREHAB**

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).
-- *Specify Program Instance(s) applicable to this authority*
☑ **MHREHAB**

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.)
- [x] **FFS** Selective Contracting program

Please describe:

Population

The population to be served under the proposed 1915(b) waiver is children and adolescents from 3-18 years of age who have a serious emotional disturbance (SED) and adults age 18 and over who have severe and persistent mental illness (SPMI), and for whom a licensed practitioner of the healing arts has determined that mental health rehabilitative services are medically necessary. The waiver covers the same population as is currently covered for Mental Health (MH) Rehabilitative Services, under the rehabilitative services option, in the Texas Medicaid State Plan.

These SED and SPMI populations require multiple specialized services from specialized providers. Nationally recognized best practices indicate that the specialized services achieve maximum effectiveness when the services delivered by physicians and other professional and paraprofessional staff are closely coordinated and monitored. A behavioral health home that provides a complete array of behavioral health services facilitates recovery by ensuring that all services are coordinated and are easily accessible to the individual. Continuity of care is often an issue because of individuals' changing level of functioning and service needs. Frequent changes in Medicaid status also create barriers to seamless service provision. Texas seeks to improve the coordination and continuity of services for this population in order to maximize the effectiveness of the services provided.

Background

Texas addressed some of the nationally recognized best practices with the implementation of Resiliency and Disease Management (RDM) in the fall of 2004. RDM was the result of over 2 years of collaboration with national experts in the field of behavioral health, providers of specialized behavioral health services, and client advocacy groups. (The results of the 2 day consensus conference are published as a special issue of the Psychiatric Rehabilitation Journal, Spring 2004, Volume 27, Number 4.) The years of collaboration brought about Texas' development of a "uniform assessment" which assertains the individual's current level of care along 9 dimensions of functioning for adults and 10 dimensions of functioning for children and adolescents. The identified level of care in turn identifies the array of comprehensive specialized services, referred to as "service packages," that have been shown to provide maximum benefit in assisting individuals with recovery. This identification of specific services to specific levels of functioning ensures that service provision will be consistent across the state and without regard to funding source(i.e.,Medicaid versus state general revenue).To maximize the effectiveness of treatment, it is necessary for individuals to receive the full array of recommended services and that these services be carefully coordinated in order to ensure both continuity of care and the proper coordination of care.

Rehabilitative Services

The waiver covers the full array of MH Rehab Services as is currently set forth in the Texas State Plan:

1. Medication Training and Support Services curriculum-based training and guidance that serves as an initial orientation for the individual in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community.

2. Psychosocial Rehabilitation Services social, educational, vocational, behavioral, and/or cognitive interventions to improve a client's potential for social relationships, occupational or educational achievement, and living skills development. This service is provided by members of a therapeutic team. When appropriate, this service addresses the impact of co-occurring disorders upon the individual's ability to decrease symptomatology and aims to increase community tenure. This service includes:

a. Independent living-skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers.

b. Coordination skills training and/or supportive interventions to assist the individual in improving

their ability to gain and coordinate access to necessary care and services. Individuals receiving Psychosocial Rehabilitation Service are not eligible to simultaneously receive Medicaid Targeted Case Management Services.
c. Employment related services-training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to make vocational choices, attain or retain employment.
d. Housing related service-training and supports that focus on the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to obtain or maintain tenure in independent integrated housing.
e. Medication related services-Training and supportive interventions focus on individual-specific needs & goals regarding the administration of medication, monitoring efficacy & side-effects of medication, & other nursing services that enable the individual to attain or maintain an optimal level of functioning. Medication related services do not include services or activities that are incidental to physician services provided during a clinical appointment.
3. Skills Training & Development-skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, & other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers. Individuals receiving Skills Training and Development are not eligible to simultaneously receive Psychosocial Rehabilitation Service.

Continued in Section A, Part 1: A. Additional Information

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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.
-- *Specify Program Instance(s) applicable to this statute*
☑ **MHREHAB**

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.
-- *Specify Program Instance(s) applicable to this statute*
☐ **MHREHAB**

c. ☑ **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.
-- *Specify Program Instance(s) applicable to this statute*
☑ **MHREHAB**

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

-- *Specify Program Instance(s) applicable to this statute*
☐ **MHREHAB**

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.

This waiver will operate in all counties of the state with the exception of those counties that are currently operating under the NorthSTAR 1915(b) waiver (i.e., Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties).

-- *Specify Program Instance(s) applicable to this statute*

☑ **MHREHAB**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
continued from A.1.d

4. Crisis Intervention-intensive community-based one-to-one service provided to individuals who require services in order to control acute symptoms that place the individual at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting. Also included is the assessment of dangerousness and, when appropriate, coordination of emergency services.
5. Day program for acute needs-short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting. Day programs for acute needs are goal-oriented, provided in a highly structured and safe environment with constant supervision, and provides an opportunity for frequent interaction between client and staff.

These services do not include any of the following: services to inmates in public institutions; services to individuals under 65 years of age residing in institutions for mental diseases; job task specific vocational services; educational services; room and board residential costs; services that are an integral and inseparable part of another Medicaid-reimbursable service, including targeted case management services, residential rehabilitative behavioral health services, institutional or other waiver services; services that are covered elsewhere in the Medicaid State Plan; services to individuals with a single diagnosis of mental retardation or other developmental disability or disorder and who do not have a co-occurring diagnosis of mental illness in adults or serious emotional disturbance in children; inpatient hospital services; respite services; family support services.

Access

Individuals receive medically necessary MH services by contacting a provider who performs a psychiatric evaluation and, through the State's uniform assessment process, determines the array of services necessary for the individual to begin the process of recovery. A licensed practitioner of the healing arts determines the medical necessity of Medicaid services within the recommended service array and then, in coordination with the individual, a treatment plan is developed that details how the services will be delivered. This same process determines what other (non-Medicaid) services are required for the individual. These essential services supplement the Medicaid services and help to ensure quality of life and opportunity to continue moving toward recovery.

Selective Contracting

Under selective contracting Texas will be able to ensure that all of the services within the service packages are provided by a coordinated group of service providers who specialize in providing services to the SED and SPMI populations. A selective provider base will allow the State to mandate providers to provide the entire array of services thereby ensuring seamless service provision. The selected providers would, within available resources, be required to provide services regardless of the individual's Medicaid status ensuring that the provider follows the person throughout the entire episode of care.

Under the proposed waiver, MH rehabilitative services are delivered by the same entities that are currently providing the spectrum of services identified in the State's RDM service model. This service model ensures that each individual has access to an integrated system of care that offers essential MH services in addition to MH rehabilitative services. It is the availability of this spectrum of services that drives both an increase in efficiency and quality. Under such a system, services are not fragmented and the consumer does not have to seek out different service providers in order to receive each of the services that may be required. In essence, the integrated system of care becomes a behavioral health home in which a number of other services are readily available within the same system of care. This improves access to care by providing a "one stop" location where all necessary MH services can be accessed.

In addition to improved access, the coordination of care is improved by having services delivered within an integrated system of care. For example, workers who deliver the rehabilitative services can easily have access to the psychiatrist providing medication management for the individual in order to coordinate care and enhance communication and feedback.

The available spectrum of services, ease of access to services, and improved coordination of care work together to drive service effectiveness and economic efficiency.

Additionally, the State monitors the quality of service delivery across the entire spectrum of care regardless of whether a particular service is a service that is reimbursed by Medicaid. For example, Assertive Community Treatment (ACT) services are delivered by every service system provider. Therefore, if an individual requires ACT services, the provider will be held to specific State quality requirements that are specific to ACT. This comprehensive approach to service quality further enhances both effectiveness and efficiency of service delivery.

Furthermore, the State monitors assessment data, encounter data, as well as billings for all services delivered by these providers regardless of billing source (ie. Medicaid and non-Medicaid services). This allows the State to evaluate provider performance across multiple areas ranging from the speed of delivery of crisis services to financial viability of the system of care to service quality for specific services. The ability to monitor and regulate these entire systems of care helps to ensure quality and fidelity to standards of practice.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☐ **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:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ◉ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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):

Procurement for MCO

- **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)

Procurement for PIHP

- **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)

Procurement for PAHP

- **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)

Procurement for PCCM

- **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)

Procurement for FFS

- **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)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
The state will contract with a single service provider in each Local Service Areas of the State (excluding the Local Service Area served by the NorthSTAR 1915(b) waiver) that provides the full array of comprehensive services that conform to the State's RDM service array.

The RDM service array includes both Medicaid state plan services and non-Medicaid services that are specifically designed to address the multiple needs of adults with SMI and children and adolescents with SED. The following services comprise the entire RDM Service Array:
A. Psychiatric Diagnostic Interview Examination
B. Pharmacological Management
C. Targeted Case Management – Site Based
D. Targeted Case Management – Community Based
E. Medication Training & Support Services
F. Engagement Activity
G. Crisis Intervention Services
H. Crisis Transportation – Event – (direct provision)
I. Crisis Transportation – (funding for)
J. Safety Monitoring
K. Day Programs for Acute Needs
L. Extended Observation
M. Crisis Residential Treatment / Crisis Stabilization Unit
N. Crisis Flexible Benefits – Events and Funds
O. Respite Services: Community-based (in home)
P. Respite Services: Program-based (not in home)
Q. Inpatient Hospital Services
R. Emergency Room Services (Psychiatric)
S. Crisis Follow-up & Relapse Prevention
T. Skills Training & Development
U. Supported Employment
V. Supported Housing Services and Supports
W. Residential Treatment (non-crisis)
X. Flexible Funds (Non-Clinical Supports & Transportation)
Y. Flexible Community Supports
Z. Counseling (CBT) (Individual)
AA. Counseling (CBT) (Group)
BB. Psychosocial Rehabilitative Services
CC. Assertive Community Treatment (ACT)

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

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 1932(a)(3) 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):

Program: " **MHREHAB.** *"*

☐ **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

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

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.

The State of Texas is divided into 38 Local Service Areas (LSAs). Thirty-seven of these LSAs are included within this waiver. The state will contract for a single Mental Health Rehabilitative Services provider within each of these 37 included LSAs. The waiver will not in the LSA in which the NorthSTAR 1915(b) waiver operates. Please refer to D 2 (below) for a listing of Texas Counties and provider for each LSA. In order to provide consumers with a choice of providers whenever possible, each LSA provider will be required to make periodic attempts to recruit and develop a network of qualified subcontracted providers. In addition, each LSA provider will be required to pay the full Medicaid rate to subcontracted providers. This approach will help to ensure that consumers are not only provided with the recommended array of evidence-based services within a behavioral health home, but will also help to ensure consumer choice is maximized within each LSA wherever such qualified providers can be recruited.

○ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

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
     -- *Specify Program Instance(s) for Statewide*
     - ☐ **MHREHAB**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     - ☑ **MHREHAB**
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)
Anderson, Cherokee	FFS -Selective Contracting	Anderson/Cherokee Community Enrichment Services
Henderson, Rains, Smith, Van Zandt, Wood	FFS-Selective Contracting	Andrews Center
Travis	FFS-Selective Contracting	Austin Travis County MHMR Center
Callahan, Jones, Shackelford, Stephens, Taylor	FFS-Selective Contracting	Betty Hardwick Center
Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, Williamson	FFS-Selective Contracting	Bluebonnet Trails Community MHMR Center
Jim Hogg, Starr, Webb, Zapata	FFS-Selective Contracting	Border Region MHMR
Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine,	FFS-Selective Contracting	Burke Center
San Augustine, San Jacinto, Shelby, Trinity, Tyler	FFS-Selective Contracting	Burke Center
Atascosa, Dimmit, Frio, Karnes, La Salle, Maverick, McMullen, Wilson, Zavala	FFS-Selective Contracting	Camino Real Community MHMR Center
Bell, Coryell, Hamilton, Lampasas, Milam	FFS-Selective Contracting	Central Counites Center for MHMR
Bailey, Briscoe, Castro, Floyd, Hale, Lamb, Motley, Parmer, Swisher	FFS-Selective Contracting	Central Plains Center
Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, San Patricio	FFS-Selective Contracting	Costal Plains Community MHMR Center
Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk, Upshur	FFS-Selective Contracting	Community Healthcore

Denton	FFS-Selective Contracting	Denton County MHMR
El Paso	FFS-Selective Contracting	El Paso MHMR
Calhoun, DeWitt, Goliad, Jackson, Lavaca, Refugio, Victoria	FFS-Selective Contracting	Gulf Bend MHMR Center
Bosque, Falls, Freestone, Hill, Limestone, McLennan	FFS-Selective Contracting	Heart of Texas Region MHMR Center
Archer, Baylor, Childress, Clay, Cottle, Dickens, Foard, Hardeman, Haskell, Jack	FFS-Selective Contracting	Helen Farabee Regional MHMR Center
King, Knox, Montague, Stonewall, Throckmorton, Wichita, Wilbarger, Wise, Young	FFS-Selective Contracting	Helen Farabee Regional MHMR Centers
Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney	FFS-Selective Contracting	Hill Country Community MHMR Center
Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, Val Verde	FFS-Selective Contracting	Hill Country Community MHMR Center
Camp, Delta, Franklin, Hopkins, Lamar, Morris, Titus	FFS-Selective Contracting	Lakes Regional MHMR Center
Cochran, Cosby, Hockley, Lubbock, Lynn	FFS-Selective Contracting	Lubbock Regional MHMR Center
Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington	FFS-Selective Contracting	MHMR Authority of Brazos Valley
Harris	FFS-Selective Contracting	MHMR Authority of Harris County
Nueces	FFS-Selective Contracting	MHMR Center of Nueces County
Tarrant	FFS-Selective Contracting	MHMR of Tarrant County
Coke, Concho, Crockett, Irion, Reagan, Sterling, Tom Green	FFS-Selective Contracting	MHMR Services for the Concho Valley
Cooke, Fannin, Grayson	FFS-Selective Contracting	MHMR Services of Texoma
Erath, Hood, Johnson, Palo Pinto, Parker, Somervell	FFS-Selective Contracting	Pecan Valley MHMR Region
Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, Presidio	FFS-Selective Contracting	Permain Basin Community Centers for MHMR
Chambers, Hardin, Jefferson, Orange	FFS-Selective Contracting	Spindletop MHMR Services
Austin, Colorado, Fort Bend, Matogorda, Waller, Wharton	FFS-Selective Contracting	Texana Center
Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall	FFS-Selective Contracting	Texas Panhandle MHMR
Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham	FFS-Selective Contracting	Texas Panhandle MHMR
Potter, Randall, Roberts, Sherman, Wheeler	FFS-Selective Contracting	Texas Panhandle MHMR
Bexas	FFS-Selective Contracting	The Center for Health Care Services
Brown, Coleman, Comanche, Eastland,	FFS-Selective	

McCulloch, Mills, San Saba	Contracting	The Center for Life Resources
Brazoria, Galveston	FFS-Selective Contracting	The Gulf Coast Center
Liberty, Montgomery, Walker	FFS-Selective Contracting	Tri-County MHMR Services
Cameron, Hidalgo, Willacy	FFS-Selective Contracting	Tropical Texas Behavioral Health
Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard	FFS-Selective Contracting	West Texas Centers for MHMR
Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry	FFS-Selective Contracting	West Texas Centers for MHMR
Upton, Ward, Winkler, Yoakum	FFS-Selective Contracting	West Texas Centers for MHMR

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

   - [x] **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
     - (•) **Mandatory enrollment**
     - ( ) **Voluntary enrollment**

   - [x] **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
     - (•) **Mandatory enrollment**
     - ( ) **Voluntary enrollment**

   - [x] **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
     - (•) **Mandatory enrollment**
     - ( ) **Voluntary enrollment**

   - [x] **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible

for Medicaid due to blindness or disability.

- (●) **Mandatory enrollment**
- ( ) **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 define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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.

- [x] **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

- [ ] **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

- [x] **Other** (Please define):

  Individuals residing in a nursing facility unless they have been determined through the PASRR process to need specialized mental health services, would not be eligible to receive mental health rehabilitative services under this waiver.
  Individuals who are being served through the NorthSTAR 1915(b) managed care waiver program. Individual's currently residing in an Institution for Mental Disease and children in Department of Family and Protective Services custody.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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).

☐ 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.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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.

Emergency Services Category General Comments (optional):
This is a waiver that pertains exclusively to mental health rehabilitative services and therefore does not cover emergency (physical health) services. It does include Rehabilitative Services delivered in mental health crisis situations. Described in the current State Plan as Crisis Intervention Services, these services are intensive community-based one-to-one services provided to individuals at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.

The RDM service array includes a variety of services that can be used to address the needs of individuals experiencing a mental health crisis. Some of these RDM services are Medicaid services and some are services funded exclusively with state general revenue dollars. The services within the RDM service array that may be used to meet the needs of a person experiencing a mental health crisis include:

A. Psychiatric Diagnostic Interview Examination
B. Crisis Intervention Services
C. Crisis Transportation – Event – (direct provision)
D. Crisis Transportation – (Funding for)
E. Safety Monitoring
F. Day Programs for Acute Needs
G. Extended Observation

H. Crisis Residential Treatment / Crisis Stabilization Unit / Crisis Respite Services
I. Crisis Flexible Benefits – Events and Funds
J. Inpatient Hospital Services
K. Crisis Follow-up & Relapse Prevention

Typically, a person who needs additional observation would receive Extended Observation Services (up to 72 hours of extended observation) or Crisis Residential Treatment or Crisis Respite, Crisis Stabilization Unit Services, or Inpatient Hospitalization depending on severity of symptoms and response to interventions.

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.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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 Category General Comments (optional):

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.

EPSDT Requirements Category General Comments (optional):
This waiver is for selective contracting for mental health rehabilitative services and is not a managed care waiver. All individuals under the age of 21 who have medical necessity for mental health rehabilitative services will have access to the mental health rehabilitative services provided under this waiver.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

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.

1915(b)(3) Services Requirements Category General Comments:

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:

Self-referrals Requirements Category General Comments:

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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.

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

For purposes of the provision of mental health services, Texas has been divided into 38 Local Service Areas. Thirty-seven of these Local Service Areas will be included in this waiver. Each of these Local Service Areas will be served by a specific provider that will be responsible for providing Mental Health Rehabilitative Services (and other specialized mental health services) to individuals residing within that Local Service Area. Each Local Service Area will provide a home where recipients with Severe Mental Illness or Serious Emotional Disturbance can receive an array of mental health services based on medical necessity. This local approach will ensure the availability of services that are proximate to the recipient's county of residence. If an individual is in a county outside of his Local Service Area and requires crisis services, the provider serving that county may also provide medically necessary Mental Health Rehabilitative Services to the individual. This approach ensures that every individual with SED has a treatment "home" but also ensures that crisis services will be available if that individual is outside of his or her Local Service Area.

The Department of State Health Services (DSHS) has established accessibility standards that apply to every provider. These standards include the following requirements:

• The provider must have a crisis screening and response system in operation twenty-four hours a day, 365 days of the year, which are available to all individuals throughout its contracted Local Service Area. Individuals currently receiving services from the service provider as well as the general public have access to the local crisis screening and response system.

• The telephone system to access the crisis screening and response system must include a local toll-free crisis hotline number and be easily accessible and well publicized. Publications usually include local and regional telephone directories, the provider's website, 211 directories, local Information and Referral hubs, and provider's public relations documents.

• Calls to the crisis hotline must be answered by a hotline staff member who is trained in compliance with this subchapter. The hotline must have teletypewriter capabilities or other assistive technology that is available and effective.

• In addition to the crisis screening and response system described in this section, the provider must ensure the availability of a telephone system and call center with a toll-free number. The call center must operate without using telephone answering equipment,on business days during normal business hours, except on national holidays, due to uncontrollable interruption of service, or with prior approval of the department. During time other than those above, the call center must provide an electronic call answering message that include an outgoing message providing the crisis hotline number, in languages relevant to the service area, for callers to leave a message. The call center must also return routine calls before the end of the next business day for all messages left after hours.

• Timely services based on need. The provider must arrange mental health services for an individual within the following time-frames.

(1)Crisis services.

(A)Hotline calls. For all calls to the toll-free crisis hotline:

(i)The call must be answered by a staff member within thirty seconds, on average, at least ninety-five percent of the time; and

(ii)If the call is identified as a potential crisis, the provider's staff must begin a telephone screening immediately but no later than one minute after the call is so identified.

(B)Crisis mental health services. If during a screening, it is determined that an individual is experiencing a crisis that may require emergency care services, the provider's staff must:

(i)Take immediate action to address the emergency situation to ensure the safety of all parties involved;

(ii)Activate the immediate screening and assessment processes as described; and

(iii)Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.

(2)Urgent care services. If the screening indicates that an individual needs urgent care services, the provider's staff must within eight hours of the initial incoming hotline call or notification of a potential crisis situation:

(A)Perform a face-to-face assessment; and

(B)Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.

(3)Routine care services. If the screening indicates that an individual needs routine care services, a qualified staff member must perform a uniform assessment within fourteen days after the screening. If the assessment indicates a level of care for routine care services, the individual must begin receiving services immediately.

Individuals eligible for Medicaid who are determined to be in need of Mental Health Rehabilitative Services, according to the DSHS performance contract with the MHMR centers, cannot be placed on a waiting list and must be served.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the State's standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

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

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

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

Please note any changes that will occur due to the use of physician extenders.:

g. **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.
The State currently has provider contracts for the delivery of MH Rehabilitative Services with only the community MHMR centers (identified under Item D2 of the waiver application). These community MHMR centers would be the only entities that would be allowed to provide Mental Health Rehabilitative Services under the waiver. As the current provider capacity will not be increased or decreased by the implementation of the waiver, the State does not anticipate an increase or decrease in enrollment or utilization under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

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.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

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

The following items are required.

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

Please provide justification for this determination:

b. ☐ **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:

Please describe the enrollment limits and how each is determined:

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.

Please describe:

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.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

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

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

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

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

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

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

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

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

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
DSHS has specific regulations relating to continuity of care and coordination for all contracted providers of mental health services. These regulations specify that providers must ensure that individuals:

i)Are provided continuity of care services that ensure uninterrupted services are provided to an individual during a transition between service types (e.g., inpatient services, outpatient services) or providers. These activities include:

(a)Assisting with admissions and discharges;
(b)Facilitating access to appropriate services and supports in the community, including identifying and connecting the individual with community resources;
(c)Participating in the individual's treatment plan development and reviews;
(d)Promoting implementation of the individual's treatment plan or continuing care plan; and
(e)Facilitating coordination and follow-up between the individual and the individual's family (as permitted by the individual), as well as with available community resources.

ii)Are informed of who to contact regarding continuity and coordination of their services and if a nursing or medical assessment indicates physical health needs outside the scope of the provider's competency, credentialing, or capacity to treat, the provider must make and document appropriate referrals to other healthcare providers and provide adequate follow-up at subsequent visits to confirm access to the referrals.

Because all Local Service Area providers are directly overseen by DSHS, continuity of care at the time of admissions, transfers between Local Service Areas, and discharges will be handled uniformly and in accordance with agency rules that were specifically developed to ensure the proper care of persons with severe mental illness or serious emotional disturbance.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

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

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

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

(mm/dd/yy)

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

Please provide the information below (modify chart as necessary):

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCM's response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to State's medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollee's PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

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

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

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ☐ Initial credentialing

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

- ☐ The utilization management system.

- ☐ The complaint and appeals system.
- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

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

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

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

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
To become a Medicaid provider of MH rehabilitative services, an entity must be established as a community MHMR center in accordance with Texas Health and Safety Code, §534.001, that:

(A) provides services comparable to MH rehabilitative services and the services described in the Texas Health and Safety Code, §534.053(a)(1)-(7);
(B) is in compliance with Texas Administrative Code (TAC), Title 25, Chapter 412, Subchapter G (relating to Mental Health Community Services Standards);
(C) conducts criminal history clearances on all contractors delivering MH rehabilitative services and all employees and applicants of the Medicaid provider to whom an offer of employment is made and ensures that individuals do not come in contact with and are not provided services by an employee or contractor of the Medicaid provider (or employee or contractor of contractors delivering MH rehabilitative services under a contract with the Medicaid provider) who has a conviction for any of the criminal offenses listed in 25 TAC §414.504(g) (relating to Pre-employment and Pre-assignment Clearance) or for any criminal offense that the Medicaid provider has determined to be a contraindication to employment; and
(D) has a Medicaid provider agreement with the State Medicaid Agency and DSHS to provide Mental Health

rehabilitative services.

The services referenced in Section 534.053 of the Texas Health and Safety Code are the following:

1.24-hour emergency screening and rapid crisis stabilization services;
2.Community-based crisis residential services or hospitalization;
3.Community-based assessments, including the development of interdisciplinary treatment plans and diagnosis and evaluation services;
4.Family support services, including respite care;
5.Case management services;
6.Medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medication; and
7.Psychosocial rehabilitation programs, including social support activities, independent living skills, and vocational training.

These standards help to ensure that each provider of Mental Health Rehabilitative Services is capable of providing a broad array of quality specialized services that are specifically designed to meet the needs of adults with Severe Mental Illness and children and adolescents with Serious Emotional Disturbance. By employing the Texas Resiliency and Disease Management model, these individuals are matched to specific services that are effective in assisting the individuals to move from illness to recovery.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

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:

Listing in phone directories and social/human services directories, 211 listings, local informal and referral listings, participation in health fairs, providing information to individuals and groups (e.g., Rotary, Parent Teacher Association), providing brochures to other health care providers and social service providers (e.g., Salvation Army), public service announcements, and press releases.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The Community MHMR Centers are required to take reasonable steps to provide services and

information both orally and in writing, in appropriate languages other than English, to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

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

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☐ The languages comprise all languages in the service area spoken by approximately _____ percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

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.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☐ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

If the State does not translate or require the translation of marketing materials, please explain:

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

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. ☐ The languages spoken by approximately _____ percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

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

3. ☐ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

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.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

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

- ☐ the State
- ☐ State contractor

Please specify:

- ☐ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

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)(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.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

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:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

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:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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 waiver proposal moves the State Plan service of MH Rehabilitative Services to a 1915(b) waiver. As the State currently contracts with the local community MHMR centers for the provision of MH Rehabilitative Services under the State Plan, there is no need for a waiver implementation schedule.

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: 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 ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process 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.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

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.

☐ 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.

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

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.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

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 section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed 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.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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 section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

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

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

b. Timeframes

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

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

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

procedure):

The grievance procedures are operated by:

- ☐ the State
- ☐ the State's contractor.

Please identify:

- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ 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.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☑ 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 A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data						

	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM ☑ FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM ☑ FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM ☑ FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM ☑ FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP	MCO PIHP	MCO PIHP	MCO PIHP	MCO PIHP	MCO PIHP

	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☑ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section 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.

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  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

	☑ FFS	☐ FFS	☑ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO	☐ MCO	☐ MCO

	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section 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.

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  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

	☐ FFS	☐ FFS	☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO	☐ MCO	☐ MCO

	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☑ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
MHREHAB	FFS;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: MHREHAB

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:

- 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)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

c. ☐ **Consumer Self-Report data**

Activity Details:

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**
☐ **Disenrollment survey**
☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:

☐ **Denials of referral requests**
☐ **Disenrollment requests by enrollee**
☐ **From plan**
☐ **From PCP within plan**

☑ **Grievances and appeals data**

☑ **Other**

Please describe:

DSHS maintains a dedicated Client Rights division that is responsible for identifying and resolving consumer complaints. This office will monitor all complaints related to Mental Health Rehabilitative Services and will coordinate with DSHS Program, Quality Monitoring and Contract Enforcement staff to ensure the rapid and proper resolution of consumer complaints.

DSHS uses statewide reports that identify improper Medicaid billing, including:

o Unauthorized and invalid services
o Claims billed for services in excess of day limits
o Claims billed for rehab and case management on the same day

Providers are able to monitor the above reports and correct any overpayments reported. DSHS also monitors these reports to ensure that the overpayments are resolved.

DSHS conducts record reviews of Medicaid paid services during on-site and desk reviews of service delivery by Quality Management and Compliance Unit to ensure health record documentation is compliant with Medicaid documentation rules and standards. Providers are required to repay any identified overpayments.

e. ☐ **Enrollee Hotlines**

Activity Details:

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)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☑ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

The State will contract with an independent entity for the assessment of cost effectiveness during the first two waiver periods.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

- ☐ **Clinical**
- ☐ **Non-clinical**

n. ☐ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

- ☐ **Survey of providers**
- ☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☐ **Other**

Activity Details:

Section C: Monitoring Results

Initial Waiver Request

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.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
MH Rehab	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	07/01/2011	06/30/2012	07/01/2012	06/30/2013
Enrollment Projections for the Time Period*	07/01/2011	06/30/2012	07/01/2012	06/30/2013

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Mental Health Rehabilitation	☑	☐	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

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

Signature:	
	State Medicaid Director or Designee
Submission Date:	
	Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Greta Rymal

c. Telephone Number:

(512) 424-6919

d. E-mail:

greta.rymal@hhsc.state.tx.us

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

- ○ **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.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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. ☐ **PCCM**
e. ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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. ☐ **Year 1: $** **per member per month fee.**
2. ☐ **Year 2: $** **per member per month fee.**
3. ☐ **Year 3: $** **per member per month fee.**
4. ☐ **Year 4: $** **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.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

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:
The available spectrum of services, ease of access to services, and improved coordination of care work together to increase service effectiveness during the economic downturn. Medicaid recipient months are trended forward using Texas Medicaid and Healthcare Partnership data for state fiscal year 2009. The 18.68 percent increase from Base Year to Projected Year 1 represents a 7.75 percent annual caseload growth trend. This number is higher than 7.75 percent due to the extended time period between the Base Year and Projected Year 1 caseload figures.

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

e. [Required] List the year(s) being used by the State as a base year:
State fiscal year 2009
If multiple years are being used, please explain:
Not applicable.

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

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

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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.

None.

The State selected "PCCM FFS Reimbursement" in the chart below (Appendix D2.S: Services in Waiver Cost) as just "FFS Reimbursment" is not available. This is a FFS-Selective Contracting waiver and no category is available for selection.

Appendix D2.S: Services in Waiver Cost

State Plan	MCO Capitated	FFS Reimbursement impacted by	PCCM FFS	PIHP Capitated	FFS Reimbursement impacted by	PAHP Capitated	FFS Reimbursement impacted by

Services	Reimbursement	MCO	Reimbursement	Reimbursement	PIHP	Reimbursement	PAHP
Mental Health Rehabilitation	☐	☐	☑	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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 Administrative Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Mental Health Rehabilitation			
Total:			

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

- ☐ **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.*
- ☐ **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.*
- ☑ **Other**

  Please explain:

  The State allocates the administrative costs based upon all waivers cost as a percentage of the total Medicaid caseload and costs, distributed to waiver/non-waiver, and the type of waiver for unduplicated client counts. These percentages are applied to individual cost categories within the total allocation amount, as applicable to the MH Rehab program.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

☐ 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.

☐ **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:

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

Basis and Method:

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

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

☐ **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.

   Document

   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)

   Document:

   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.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

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:

3.50

Please document how that trend was calculated:
The State Plan annual trend factor of 3.50 percent is based on the most recent available annual trend for Medical Care Services Consumer Price Index factors. This information is based on national averages from 2009-2010 and was obtained from the U.S. Bureau of Labor Statistics. The Projected Year 1 trend of 10.24 percent is derived by applying the 3.5 percent annual trend over the thirty-four month period between the midpoint of the Base Year and Projected Year 1.

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

i. ☐ State historical cost increases.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ☑ National or regional factors that are predictive of this waiver's future costs.

Please indicate the services and indicators used.
Medical Care Services (All Urban Consumers) 2009-2010 Average, U.S. Cities Bureau of

Labor Statistics
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.
MH Rehab services will follow medical care cost trends in the future. There were no other factors included in the calculation.

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.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

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**

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.
Please list the changes.

For the list of changes above, 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 list the changes.

For the list of changes above, 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 list the changes.

For the list of changes above, 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

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

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)
Please describe

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
The administrative cost trend was developed based on recent years' changes in the average administrative cost per client. The P1 trend of 5.77 percent is derived by applying the 2 percent annual trend over the thirty-four month period between the midpoint of the base year and P1.

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.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

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

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

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

1. ☐ Payments outside of the MMIS were made.

   Those payments include (please describe):

2. ☐ Recoupments outside of the MMIS were made.

   Those recoupments include (please describe):

3. ☐ The State had no recoupments/payments outside of the MMIS.

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

Basis and Method:

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

   Please describe

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

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

***Method*:**

1. ☐ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine copayment adjustment based on pending SPA.
3. ☐ Determine copayment adjustment based on currently approved copayment SPA.
4. ☐ Other

   Please describe

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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.

   Please describe
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. ☐ Ohter

   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:
   - i. ☐ Potential Selection bias was measured.

     Please describe
   - ii. ☐ The base year costs were adjusted.

     Please describe

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

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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	

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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. ☐ Other

   Please describe

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. This adjustment must be mathematically accounted for in Appendix D5.

   Please describe

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

This section is only applicable to Renewals

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

This section is only applicable to Renewals

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

This section is only applicable to Renewals

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

This section is only applicable to Renewals

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Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

This section is only applicable to Renewals

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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.

No adjustments were made.
Appendix D5 – Waiver Cost Projection

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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.

Medicaid recipient months are trended forward using Texas Medicaid and Healthcare Partnership service claims by risk group for state fiscal year 2009.
Appendix D6 – RO Targets

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M. Appendix D7 - Summary

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

The State Plan annual trend of 3.5 percent and the administrative adjustment annual trend of 2 percent contribute to the overall percentage change in spending.

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:

The available spectrum of services, ease of access to services, and improved coordination of care work together to increase service effectiveness during the economic downturn. Medicaid recipient months are trended forward using Texas Medicaid and Healthcare Partnership data for state fiscal year 2009.

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:

None.

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:

None.

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

No other principal factors.

Appendix D7 - Summary