

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

October 1, 2009-September 30, 2011

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Instructions – see separate document

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

Facesheet

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

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

The **name of the waiver program** is **NorthSTAR**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part _____
 - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
 - Document is replaced in full, with changes highlighted
- renewal request
 - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
 - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
 - Section A is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
 - Sections A and B of the previous waiver renewal are included in their entirety. Minor changes and updates have been made.
 - Section B is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Monitoring Plan from the previous waiver period.

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

Effective Dates: This waiver/**renewal**/amendment is requested for a period of two years; effective October 1, 2009, and ending September 30, 2011. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Betsy Johnson and can be reached by telephone at (512) 491-1199, or fax at (512) 491-1953, or e-mail at betsy.johnson@hhsc.state.tx.us.

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.

There are no Federally-recognized Tribes in the NorthSTAR service delivery area.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

RESPONSE:

- Milestones

During the initial waiver approval period, the State of Texas issued a Request for Application for the competitive selection of two behavioral health organizations to provide managed behavioral healthcare services to NorthSTAR recipients. Five responses to the Request for Application were received and Magellan Behavioral Health and ValueOptions were selected to provide managed care services for NorthSTAR recipients. On June 30, 1999, CMS provided authorization for federal financial participation to operate NorthSTAR as a voluntary managed care program for a period of one year (or until such time as the waiver was approved for mandatory enrollment). In July 1999, Magellan and ValueOptions began delivering services to NorthSTAR enrollees. The vast majority of these early enrollees were not Medicaid eligible, however a small number were voluntary Medicaid enrollees.

On September 7, 1999, the State of Texas received initial approval from the Centers for Medicare & Medicaid's (CMS) Division of Medicaid and State Operations for the implementation of NorthSTAR as a mandatory program under a 1915(b) waiver. On October 14, 1999, CMS granted a request by the State to delay the implementation date of the waiver until November 1, 1999. After receiving CMS's initial authorization for implementation, the State's enrollment broker began the distribution of educational materials printed in both English and Spanish to all Medicaid recipients residing in the NorthSTAR service area. The Enrollment Broker also began a coordinated series of community educational events and enrollment outreach activities designed to raise community awareness and to answer questions from eligible individuals and the public concerning NorthSTAR.

To assure that consumers and the local community were given a voice in the implementation and ongoing oversight of NorthSTAR, the State created an independent Local Behavioral Health Authority which came to be known as the

North Texas Behavioral Health Authority. North Texas Behavioral Health Authority provides ombudsman services to NorthSTAR enrollees, provides staff to serve on the Quality Improvement Committee of the contracted behavioral health organizations, and serves as a conduit to relay issues of community concern and complaints directly to the State. The Local Behavioral Health Authority staff also meets regularly with various community based organizations, consumer and advocacy groups, managed care coordination groups as well as NorthSTAR service providers. The Local Behavioral Health Authority began providing services to NorthSTAR enrollees in July 1999.

In February 2000, the State sought an amendment to the waiver to expedite the enrollment of pregnant women into the NorthSTAR program. This amendment was approved by CMS on April 5, 2000. In May 2000, the State sought a second amendment to the waiver to adjust the upper payment limit calculations to delete recipient months associated with populations that were not covered under the waiver. This amendment request was approved by CMS on June 28, 2000.

The State provided notification to CMS in mid-June 2000, that Magellan Behavioral Health was likely to decline the renewal of the NorthSTAR contract for a second year. On June 30, 2000, the former Texas Department of Mental Health and Mental Retardation (TDMHMR) received official notification from Magellan that they would not be renewing the contract for a second year. Magellan did agree to continue to provide services to enrollees during a sixty-day transition period. The State sought a third amendment to the waiver to allow NorthSTAR to operate with a single behavioral health organization until such time as a replacement for Magellan could be obtained. At that time the State believed that a replacement for Magellan could be obtained and attain full operational status on or before November 1, 2001. ValueOptions began providing services to all NorthSTAR recipients on October 1, 2000.

In accordance with the timetable provided to CMS, the State issued a Request for Application for the competitive selection of a behavioral health organization to replace Magellan. In response to the Request for Application the State received three preliminary (non-binding) letters of intent - but no formal applications were received. On February 15, 2001, the State provided verbal notification to CMS that no bidders had responded to the Request for Application. The State believes that the financial incentives may be inadequate to attract multiple behavioral health organizations to provide services under NorthSTAR. The State was granted permission by CMS to operate with a single contracted behavioral health organization with the approval of the waiver submission beginning November 1, 2001, and ending October 31, 2003. CMS continued to approve having a single contract behavioral health organization for each following waiver period. With this submission the State again requests CMS permission to operate with a single contracted behavioral health organization for the duration of the waiver period beginning October 1, 2009, and ending September 30, 2011. The State executed a

renewal contract with ValueOptions for the period of November 1, 2007 -August 31, 2009.

The State intends on issuing a request for proposal in state fiscal year 2010, for contract implementation in state fiscal year 2012. It is the intent of the State to procure two behavioral health organizations if possible. It was not the intent of the State to change the rationale for operating under one BHO, and all efforts will be made to secure two BHOs for the program.

On April 7, 2001, NorthSTAR was named as a semifinalist in the Innovations in American Government Awards Program, an awards program of the Institute for Government Innovation at the John F. Kennedy School of Government at Harvard University. This awards program is administered in partnership with the Council for Excellence in Government. On October 3, 2002, NorthSTAR was named in the top 100 of the same program.

On July 25, 2005, the Department of State Health Services issued a Request for Proposal for the procurement of a behavioral health organization for the provision of behavioral health and chemical dependency services to the eligible residents in the NorthSTAR service delivery area through the NorthSTAR program. Multiple proposals were received. After review and evaluation of all proposals submitted, the 2006-2007 contract was awarded to ValueOptions of Texas, Inc. The ValueOptions of Texas, Inc. contract was renewed in 2007.

In April 2008, CMS approved the behavioral health organization's Medicaid per member per month rate development, to include costs for certain services that are provided "in lieu of" Medicaid state plan services. This is consistent with CMS' guidance to other Medicaid managed care programs operating under 1915(b) waivers.

Below is the information regarding the in lieu of services. This information was removed from the waiver submission as the inclusion of the services below in the capitation rate methodology was formally approved by CMS in a letter dated April 22, 2008.

In Lieu of Services

The BHO, where cost effective and in the best interest of the member, can utilize alternative services as a substitution for Medicaid State Plan services if these services provide the desired outcomes. Part of the flexibility of the BHO service delivery model is that the BHO can develop networks to meet members' needs that are medically appropriate and responsive to the needs of the members. The BHO is not restricted to only delivering state plan services when alternative services are a cost-effective and medically appropriate response to the needs of the member.

The BHO is responsible under its contract to provide the inpatient services in a hospital setting for the treatment of alcohol/drug abuse or dependence treatment. The BHO may choose to provide these services in a more efficient manner by utilizing other DSHS-licensed facilities in lieu of acute care inpatient hospitals.

This waiver amendment seeks CMS’ approval to include the costs for these alternative services in the NorthSTAR Medicaid PMPM rate development. This inclusion of alternative services is consistent with CMS’ guidance to other Medicaid managed care programs operating under 1915(b) waivers.

Table 1 outlines Clinical Equivalency of these alternative services with Medicaid State Plan Services. Table 2 outlines costs savings associated with using in-lieu-of services.

Table 1: Clinical Comparison of in-Lieu-of Services and State Plan Services

NorthSTAR State Plan Alternative Service	Service Description/Criteria for Admission
Intensive Crisis Residential Services In lieu of inpatient hospital	Short-term and offered to consumers who are demonstrating psychiatric crises that cannot be stabilized in a less restrictive setting. This 24-hour supervised, community based, short-term treatment model serves as an alternative to inpatient hospitalization. In this facility-based program, consumers in urgent/emergency need can receive crisis stabilization services in a safe, structured setting, with continuous 24-hour observation and supervision. Services at this level of care include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family support and community resources. The primary objective of the crisis residential service is to promptly conduct a comprehensive assessment of the child/adolescent and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the child/adolescent to a level of functioning which requires a less restrictive level of care. Duration of services generally is 1 - 14 days by which time a determination of the appropriate level of care will be made and facilitation of appropriate linkages coordinated by treatment team. Treatment is provided in a DSHS-SAlcensed facility.
Medically Monitored Outpatient Detoxification In lieu of Detoxification (in-patient medical)	Non-hospital, 24-hour supervised residential treatment program that provides a planned, structured, and organized physician-supervised detoxification program to treat individuals with a diagnosis of chemical dependency. Treatment is provided in a DSHS-licensed facility.
24-hour Residential Chemical Dependency Rehabilitation Program In lieu of Detoxification (in-patient medical)	Non-hospital, 24-hour supervised residential treatment program that provides a planned, structured and organized program to treat chemical dependency. Treatment is provided in a DSHS-licensed facility.
Outpatient Chemical Dependency Program (adults) In lieu of Detoxification (in-patient medical)	Treatment program that provides 10 or more hours per week of clinically intensive chemical dependency services. Treatment is provided in a DSHS-licensed facility.
Pharmacological Maintenance Therapy for Opioid Dependence In lieu of Detoxification (in-patient medical)	Treatment program for opiate dependent clients supervised by a physician following State and Federal regulations. Treatment is provided in a DSHS-licensed facility.
Specialized Female Chemical	Treatment program for pregnant and post-partum women and women with dependent

Dependency Services In lieu of Detoxification (in-patient medical)	children (inclusive of females in treatment who are attempting to regain custody of their children) that, in addition to gender-specific residential and outpatient chemical dependency treatment, includes primary medical care for females receiving treatment; other therapeutic interventions for females that may address issues of relationships, sexual and physical abuse and parenting; childcare while females are receiving services; therapeutic interventions for children with potential for substance abuse, and their issues of sexual and physical abuse and neglect; referrals for appropriate medical care for women and their children; and sufficient case management and transportation services to ensure that female clients and their children have access to the services described above. Treatment is physician-supervised, and is provided in a DSHS-licensed facility.
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State Plan Service	Service Description/Criteria for Admission
Inpatient Hospital	Medically necessary services furnished by a hospital under the direction of a physician. Includes DRGs 433, 521, 522, 523 (alcohol/drug dependence rehabilitation and detoxification). DRG 433: alcohol/drug abuse or dependence treatment, left against medical advice. DRG 521: alcohol/drug abuse or dependence treatment with comprehensive care. DRG 522: alcohol/drug abuse or dependence treatment with rehab therapy, without comprehensive care. DRG 523: alcohol/drug abuse or dependence treatment without rehab therapy, without comprehensive care.
Detoxification (in-patient medical)	Medically necessary services furnished by a hospital under the direction of a physician. Includes DRGs 433, 521, 522, 523 (alcohol/drug dependence rehabilitation and detoxification). DRG 433: alcohol/drug abuse or dependence treatment, left against medical advice. DRG 521: alcohol/drug abuse or dependence treatment with comprehensive care. DRG 522: alcohol/drug abuse or dependence treatment with rehab therapy, without comprehensive care. DRG 523: alcohol/drug abuse or dependence treatment without rehab therapy, without comprehensive care.

Table 2: Average per-Medicaid Member Cost of Alternative Services compared with Medicaid State Plan Services

Average alternative service cost per NorthSTAR Medicaid utilizer	Average cost per NorthSTAR Medicaid utilizer if State Plan service was used	Increase in average cost per NorthSTAR Medicaid utilizer if State Plan service was used	Comments
\$ 884.74	\$ 2,161.01	\$1276.27 (144% increase)	State Plan costs represent average of DRGs 433, 521, 522, 523

- Consumer and Advocate Involvement

NorthSTAR has been generally well received by consumers and advocates throughout the service area. Various organizations, including the local chapters of the National Alliance for the Mentally Ill serving the NorthSTAR area and the Mental Health Association of Greater Dallas, have been vocal supporters of NorthSTAR. Several specific benefits that are unique to NorthSTAR have been cited by consumers and advocates. These benefits include:

1. A choice of providers
2. Choice of the most appropriate treatment and services
3. Continuity of care (for people who gain or lose Medicaid eligibility)
4. Improved access to services

5. Local oversight with ombudsman services available (provided through the Local Behavioral Health Authority)
6. Positive outcomes resulting from a total separation of authority and provider entities (i.e., the entity responsible for authorization is not the provider of services)
7. A sense of inclusion which was a result of providing formal channels for both consumer and advocate input in the early planning and implementation phases of the program
8. The elimination of waiting lists (for non-Medicaid consumers)

NorthSTAR incorporates specific features to help ensure consumer involvement including:

Adult Satisfaction Survey

Texas utilizes the Mental Health Statistical Improvement Program's adult consumer survey to collect data on consumer satisfaction and perception of care. This waiver cycle, the Texas Health and Human Services Commission (HHSC) conducted the survey statewide, while stratifying for NorthSTAR to ensure that sufficient numbers of surveys were completed to represent the program. A total of 192 adults who received services through NorthSTAR returned completed surveys.

The surveys were sent in April and May 2008. Consumers were informed that the survey was voluntary, confidential, and that their providers would not see their individual responses. They were asked to send the completed survey directly to HHSC by August 31, 2008. When a survey was returned unopened due to an incorrect address, HHSC attempted to find a more recent address and resend the survey.

Each survey item is a positive statement about services, such as "Overall, I am satisfied with the services I received." The survey items are grouped into "domains": Satisfaction, Quality/Appropriateness, Access, Participation in Treatment, Social Connectedness, Functioning, and Outcomes.

The table below reflects responses from adult enrollees in NorthSTAR.

**FY 2008 Texas Adult Mental Health Survey
NorthSTAR Domain Agreement Rates**

	NorthSTAR Agreement Rate	Lower - Upper Confidence Interval at 95 percent
Satisfaction	83%	<i>77% - 88%</i>
Quality	73%	<i>66% - 79%</i>
Access	67%	<i>60% - 74%</i>
Participation	57%	<i>50% - 64%</i>
Social	53%	<i>45% - 60%</i>
Functioning	52%	<i>44% - 59%</i>
Outcome	46%	<i>39% - 54%</i>

We note that the much lower response rate for the 2008 Adult Survey (192 responses compared to 312 responses in 2006) may have contributed to the lower overall Agreement Rates. The State continually works with the BHO and the LBHA to coordinate monitoring in order to ensure that high quality services are delivered to our enrollees. There was a recent transition of leadership at the LBHA, and the State anticipates that our new stronger relationship will aid in intensifying program oversight. We are also expecting that our expanded performance indicator monitoring process will yield even more information about areas where we can improve service delivery and outcomes.

Family Survey

Texas also utilizes the Mental Health Statistical Improvement Program's Youth Services Survey for Families to collect data on consumer satisfaction and perception of care. This waiver cycle, HHSC conducted the survey statewide, while stratifying for NorthSTAR to ensure that sufficient numbers of surveys were completed to represent the program. A total of 203 parents of children who received services through NorthSTAR returned completed surveys.

The surveys were sent in April and May 2008. Parents were informed that the survey was voluntary, confidential, and that their child's provider would not see their individual responses. They were asked to send the completed survey directly to HHSC by August 31, 2008. When a survey was returned unopened due to an incorrect address, HHSC attempted to find a more recent address and resend the survey.

Each survey item is a positive statement about services, such as “Overall, I am satisfied with the services my child received.” The survey items are grouped into “domains”: Cultural Sensitivity, Participation in Treatment, Social Connectedness, Satisfaction, Access, Outcomes, and Functioning.

The table below reflects responses from family members in NorthSTAR.

**FY 2008 Texas Youth Services Survey for Families
NorthSTAR Domain Agreement Rates**

	NorthSTAR Agreement Rate	Lower - Upper Confidence Interval
Cultural	85%	<i>79% - 89%</i>
Participation	81%	<i>75% - 86%</i>
Social	79%	<i>73% - 84%</i>
Satisfaction	75%	<i>69% - 81%</i>
Access	76%	<i>70% - 82%</i>
Outcome	59%	<i>52% - 66%</i>
Functioning	58%	<i>51% - 65%</i>

As with the Adult Survey, there was a lower response rate for the Youth Survey in 2008. Again, low response rates in general are suspect when executing mail-out surveys. The State does, however, note that the domains of Social Connectedness and Outcomes showed improvement over the 2006 results. As previously mentioned, we have developed strong oversight relationships with the BHO and the LBHA to continually monitor the quality and efficacy of the various aspects of the NorthSTAR program. We anticipate an increased ability to detect and address areas of concern using our new performance indicator monitoring process.

The NorthSTAR program supports an ongoing commitment to providing quality services and improving consumer satisfaction. We work with the behavioral health organization and the local behavioral health authority to closely monitor service provision and solicit input from consumers.

- Consumer Involvement

NorthSTAR was designed with specific features to ensure that consumers, family members, advocates and concerned citizens have the ability to voice their concerns and suggestions regarding how the NorthSTAR program was designed and how the program operates on a day-to-day basis. **The State uses a multi-**

pronged approach for soliciting consumer input and incorporating that into the program. The BHO has a prevention education and outreach department that ensures that adequate communication and outreach exists between the BHO and the consumer stakeholder community (Mental Health America, National Alliance on Mental Illness, Consumer and Family Advisory Council, etc). An example of how consumer input has resulted in development of the program is in the development of new programs. Over the last few years, there has been broad stakeholder input into the development of ideas for a enhancements to the crisis response system in NorthSTAR. This input was solicited through a series of town hall type meetings as well as presentations to the various consumer groups. Through that discussion and feedback, the crisis response system was developed that took consumer input into consideration.

To assure that consumers and the local community were given strong representation in the implementation of NorthSTAR, the State created an independent Local Behavioral Health Authority which provides the local community with a voice for expressing concerns and suggestions related to NorthSTAR. The Local Behavioral Health Authority, also known as the North Texas Behavioral Health Authority works directly with consumers, families, providers and various local groups and organizations to gather input from the community. The Local Behavioral Health Authority then provides a monthly report to the State which details consumer and community contacts and identifies relevant issues related to the NorthSTAR program from a local perspective.

The NorthSTAR behavioral health organization also participates in public meetings in order to better serve the needs of consumers and the local community.

From the time of initial implementation, multiple routine advisory meetings have been ongoing. The behavioral health organization, the Local Behavioral Health Authority, and the State routinely attend all advisory meetings.

Principle ongoing advisory meetings:

- Regional Advisory Committee (consumers and stakeholders, i.e. providers, HMOs, interacting agencies)
- Medical Care Advisory Committee-Quarterly meetings
- Local Behavioral Health Authority monthly board meetings
- Local Behavioral Health Authority consumer and family advisory committee—Generally held monthly
- Other community stakeholder meetings: The behavioral health organization and Local Behavioral Health Authority attend the local Community Mental Health Center board meetings, the National Alliance for the Mentally Ill meetings, the Community Resource Coordination Group meetings, and meetings of the Dallas County Medical Society
- The behavioral health organization attends a variety of community groups on a regular basis such as the Mental Health Authority’s child advisory

committee, the Association of Person's Affected by Addiction, the Consumer Council for Mental Health Advocacy, and Offenders with Mental Impairments meetings

Additionally, both Local Behavioral Health Authority and consumers are included in the behavioral health organization's Quality Improvement committees. This provides a direct opportunity for these groups to have regular, systematic involvement in the clinical operations of the plan. (All Quality Improvement, Utilization Management, provider issues, enrollee issues, complaints, and ongoing evaluative studies are reviewed in these quarterly meetings).

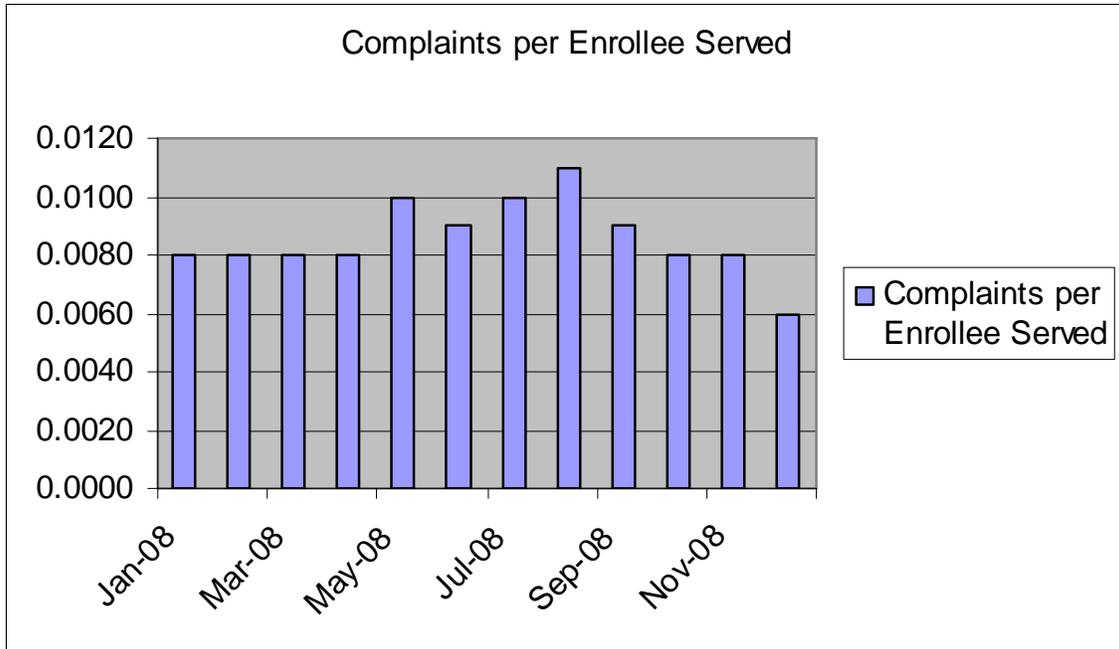
Furthermore, State staff has met independently with numerous advocates, consumer and community organizations and groups, including:

- National Alliance for the Mentally Ill Dallas
- National Alliance for the Mentally Ill Collin Co.
- Mental Health Association of Dallas
- Coalition on Mental Illness
- Dallas County Medical Society
- Special Need Offenders Workgroup
- Area Community Resource Coordination Groups (for children)
- Texas Medical Association

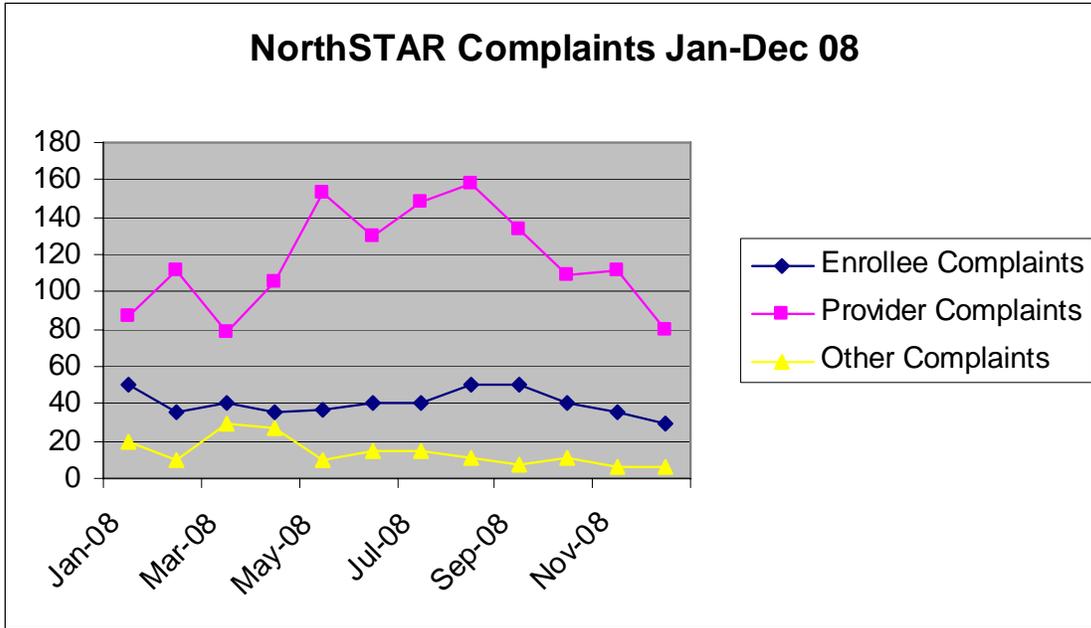
Another way consumers shape how the system is designed is through the use of an actively managed comprehensive complaint and appeal system. This comprehensive system incorporates all complaints and appeals from the BHO, local behavioral health authority and State into a standardized system. By actively ensuring this system is accessible and monitored, it enables the State to use the trends in complaints and issues to improve the program.

Complaints

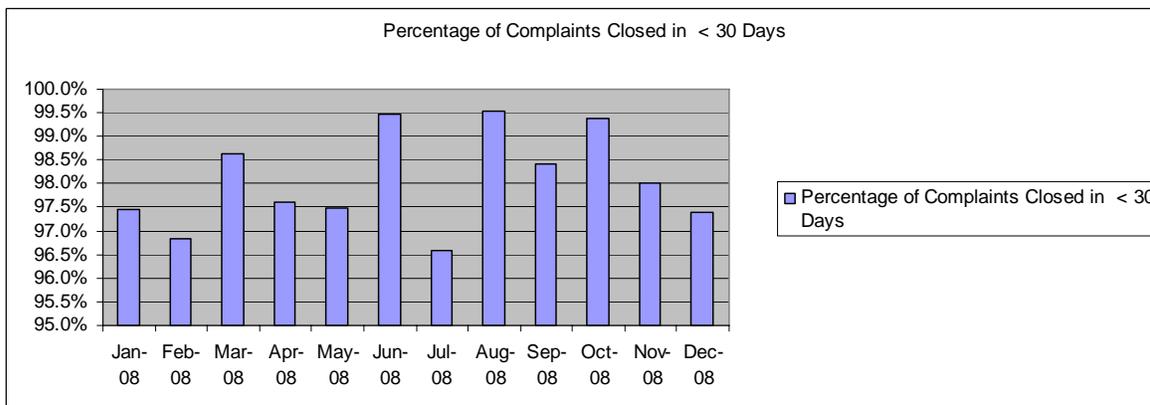
While the State recognizes that complaint-based evaluations have certain limitations, when used properly this approach can serve as an early warning system for consumer or provider concerns. Throughout the multiple waiver periods, the State continues to develop and refine the complaint system that allows the State to flag potential individual and system problems.



From January 2008-December 2008, the monthly rate of complaints from providers and consumers remained fairly low. In May 2008 there was a spike in provider complaints with 68 percent of all complaints related to provider claims issues. During the peak months, June-September 2008, 73 percent of all claims issues came from less than four separate providers and the majority were related to authorization issues and claims filed outside the allowable timeline. The behavioral health organization and the State continue to analyze data to identify any potential problems and to intervene with technical assistance when needed.



Through review of the data, enrollee complaints related to access to care and quality of care remain low. Department of State Health Services continues to work with the Local Behavioral Health Authority and the behavioral health organization to ensure enrollees are knowledgeable of the complaint process and the appropriate complaint contact information is available in provider waiting rooms and is posted in the Department of State Health Services NorthSTAR provider bulletin.



A. Statutory Authority

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

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

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

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

- a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be

available to other Medicaid beneficiaries not enrolled in the waiver program.

- c. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
- d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

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

- a. **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP**: Prepaid Inpatient Health Plan means an entity that:
 - (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis.
 The PIHP is paid on a non-risk basis.
- c. **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not

provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

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

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

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

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

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

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

1. **Assurances.**

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

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

Since 2000, CMS has approved having a single behavioral health organization. We believe that the provider network is sufficiently diverse and consumers have adequate access to service providers as illustrated by the low number of complaints. Also neither the local authority nor the local advocacy groups have issued concerns regarding the NorthSTAR provider network

The State requests CMS permission to operate with a single contracted behavioral health organization for the waiver period beginning October 1, 2009, and ending September 30, 2011.

The State intends on issuing a request for proposal in state fiscal year 2010, for contract implementation in state fiscal year 2012. It is the intent of the State to procure two behavioral health organizations if possible. It was not the intent of the State to change the rationale for operating under one BHO, and all efforts will be made to secure two BHOs for the program.

NorthSTAR is a fully capitated behavioral health carve-out that serves enrollees in seven North Texas counties, including two urban counties (Dallas and Collin) and five rural counties (Ellis, Hunt, Kaufman, Navarro and Rockwall). When NorthSTAR was initially implemented, the State selected two competing behavioral health organizations (Magellan Behavioral Health Inc. and ValueOptions) to provide services to eligible residents of the service area. Magellan withdrew from NorthSTAR after the first year, and ValueOptions became the single behavioral health organization in the area.

As the single contracted behavioral health organization, ValueOptions offers consumers a diverse, stable provider network. There is adequate provider choice, and a full array of behavioral services is available and accessible. The limited number of consumer complaints and few concerns from the local authority and advocacy groups illustrate the success of the behavioral health organization in meeting the behavioral health care needs of its enrollees.

The state intends on reprocurring the contract for the NorthSTAR program during the upcoming waiver period. The state will make every effort to procure a second behavioral health organization at that time. The anticipated contract(s) for this procurement would be effective September 1, 2011.

2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):
 - ___ Two or more MCOs

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

Please refer to the explanation in C.1. Assurances above.

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)): Ellis, Hunt, Kaufman, Navarro and Rockwall.

4. 1915(b)(4) Selective Contracting

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

D. Geographic Areas Served by the Waiver

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

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

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Medicaid/ Service Delivery Area 6	PIHP	ValueOptions
Dallas/ Dallas County Collin/Ellis/Hunt/ Kaufman/Navarro/ Rockwall counties		

E. Populations Included in Waiver

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

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

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
(SSI)
 Voluntary enrollment

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

Mandatory enrollment
 Voluntary enrollment

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

Mandatory enrollment
Under NorthSTAR, the State will provide services to individuals who are SSI eligible and to Medicaid Qualified Medicare Beneficiaries, but will not provide services to Qualified Medicare Beneficiaries.
 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.

Although State Foster Care children are not specifically covered in this waiver, these children will be covered for a transition period from the waiver to traditional Fee for Service Medicaid . Children receiving services under the waiver, who are removed from the home by Child Protective Services and placed into foster care, will transition from NorthSTAR to Fee for Service at the beginning of the month following the month of their removal or at the first possible month due to state Medicaid systems close schedule. Services are provided for a transition period only and not ongoing while the child remains in foster care.

Mandatory enrollment
 Voluntary enrollment

TITLE XXI State Children’s Health Insurance Program 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 through the Medicaid program.

Mandatory enrollment
 Voluntary enrollment

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

Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

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

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.

Medically Needy Program Type 55

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.

State Children’s Health Insurance Program Title XXI Children – Medicaid beneficiaries who receive services through the State Children’s Health Insurance Program program.

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

Other (Please define):

Individual’s receiving services through the State’s Institution for Mental Disease (Medicaid) over age 65 program and children in Department of Family and Protective Services custody.

F. Services

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

1. Assurances.

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

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

X 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). Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.

NorthSTAR is a behavioral health carve-out and does not offer physical health emergency services.

Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b).

NorthSTAR is a behavioral health carve out, as such, it does not offer family planning services.

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

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

will be available in the same amount, duration, and scope as they are under the State Plan.

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

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

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

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

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

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

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

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

___ Other (please explain):

Family planning services are not included under the waiver.

NorthSTAR is a behavioral health carve out, as such, it does not offer family planning services.

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.

5. **Early, Periodic Screening, Diagnosis, and Treatment 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 program.

6. **1915(b)(3) Services.**

- This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

- The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:
The behavioral health organization provides emergency behavioral health care services (including mobile crisis services) without prior authorization. The

behavioral health organization provides medication management services without prior authorization.

The State gives the behavioral health organization latitude to set pre-authorization requirements for certain non-emergency services. The behavioral health organization has elected to relax certain pre-authorization requirements for several services where medical necessity has been determined by the provider. Supportive outpatient for Chemical Dependency services, can be delivered without pre-authorization, up to 20 units per enrollee.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

1. PCPs (please describe):

2. Specialists (please describe):

3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):

5. ___ Mental Health (please describe):

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

7. ___ Other providers (please describe):

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

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

B. Capacity Standards

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

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

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

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

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

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

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

- b. ___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State’s standard.
- c. ___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State’s standard for adequate PCP capacity.
- d. ___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State’s PCCM program and complete the following.

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

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

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

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>
<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

- a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan’s scope of services, and how the State has organized the delivery

system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

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

In addition to identification by Medicaid program and type through the State's enrollment system, the behavioral health organization is required to provide a clinical screening for all children who present for services. This screening will be utilized by the clinician to determine the complexity of the child's needs and to help determine if the individual will be best served through the Specialty Provider Network or through other providers in the network. Individuals with multiple or complex needs will be referred to the Specialty Provider Network when clinically indicated. When a child is referred to the Specialty Provider Network, a standardized assessment is performed which more specifically targets behavioral symptomology and functional deficits. This screening/assessment procedure serves to enhance the treatment planning and service delivery process for each child with complex needs.

Additionally, the behavioral health organization is required to coordinate assessment, treatment, referral, and follow-up services for children who use multiple providers and services, sites and levels of care within the behavioral health organization's plan and other agencies or health care plans. Formal coordination agreements and guidelines for the coordination of services have been developed to help ensure that care for individuals with co-occurring physical and behavioral health needs are closely coordinated between the physical health care (State of Texas Access Reform) HMOs and the NorthSTAR behavioral health organization.

- c. X **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

During initial implementation, the State Medicaid Enrollment Broker worked closely with the State to develop staff training materials and to ensure that staff was properly trained in addressing the special needs of persons with mental illness. Additionally, the Enrollment Broker has had significant experience in the State of Michigan in providing enrollment services to children with special needs, and they have drawn on this experience in Michigan to provide specific training to its NorthSTAR enrollment counselors. The training is designed to highlight the needs of

this special population with emphasis on communication to individuals with special needs. The positive performance of the Enrollment Broker during the previous waiver cycles has demonstrated that this specialized training has been both beneficial and effective. The State will continue to work with the Enrollment Broker to further improve and enhance training during the upcoming waiver cycle.

The behavioral health organization is contractually required to ensure that a behavioral health assessment and treatment plan is completed within three days of a routine outpatient visit and within 48 hours of an emergency or urgent inpatient or residential placement. The behavioral health organization must ensure that the treatment plan is updated at least weekly for inpatient or residential treatment and every ten visits for enrollees receiving outpatient services, but not less frequently than every three months.

d. X **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

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

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

As a behavioral health "carve-out" NorthSTAR does not provide primary care services, including the development of primary care treatment plans. Individualized treatment plans formulated to address behavioral health needs are developed by providers in the behavioral health organization provider network.

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

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

- a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
 - b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
 - c. ___ Each enrollee is receives **health education/promotion** information. Please explain.
 - d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
 - e. ___ There is appropriate and confidential **exchange of information** among providers.
 - f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
 - g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
 - h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
 - i. ___ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
5. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
- The behavioral health organization and providers are contractually required to provide services according to clinical assessment of need (established clinical criteria). The behavioral health organization and the State perform systematic checks of the utilization management process (site reviews and desk reviews/data analysis) to ensure that services are delivered according to clinical needs of enrollees.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on May, 2003.

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

Program	Name of Organization	Activities Conducted		
		External Quality Review Organization study	Mandatory Activities	Optional Activities
PIHP	Institute for Child Health Policy	Annual	1)Data certification	
PIHP	Institute for Child Health Policy	September 19, 2008 – Survey	1.Administrativor Survey 2. Onsite review	

The EQRO does a formal annual review of NorthSTAR, the last of which occurred on September 19, 2008. The process consists of an Administrator Survey that is completed by the BHO, followed by a day of onsite interviews with BHO staff to review, discuss and, if necessary, clarify survey responses. The review provides a comprehensive structure and process to evaluate the BHO’s performance relative to implementing the program and serving enrollees.

2. Assurances For PAHP program.

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

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

_____ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply

with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

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

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

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

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

4. ___ Refer to program staff for further investigation;

5. ___ Send warning letters to PCCMs;

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

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

8. ___ Change an enrollee's PCCM;

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

10. ___ Further limit the number of assignments;

11. ___ Ban new assignments;

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

13. ___ Suspend or terminate PCCM agreement;

14. ___ Suspend or terminate as Medicaid providers; and

15. ___ Other (explain):

c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to

allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

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

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ___ Initial credentialing
 - B. ___ Performance measures, including those obtained through the following (check all that apply):
 - ___ The utilization management system.
 - ___ The complaint and appeals system.
 - ___ Enrollee surveys.
 - ___ Other (Please describe).
4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ___ Other (please describe).

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

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

The State participates in the behavioral health organization Quality Management Committee meetings and monitors the Utilization Management process on an ongoing basis. A biannual on-site review is conducted and network adequacy is monitored monthly. The quarterly NorthSTAR Data Book tracks performance on chemical dependency and mental health quality measures using national benchmarks (Health Plan Employer Data and Information Set) for comparison. In September 2004, the State Resiliency & Disease Management model was implemented for adults, children, and adolescents. The model mandates staff competency requiring State-sponsored training in cognitive behavioral therapy and psychosocial rehabilitation. The State Resiliency & Disease Management model also specifies the frequency and intensity of services to be delivered and the State is monitoring performance in this area. All quality measures are deemed as having equal importance and thus are not weighted. The State considers each performance measure individually and looks for indicators of concern, requiring corrective action if necessary.

The behavioral health organization implemented a provider profiling system in October, 2006. In addition, in 2009 the State implemented a new Performance Indicator instrument that looks at a much wider array of performance measures than were being tracked previously. These new measures will be integrated into the NorthSTAR Data Book, thus producing a much more comprehensive view of mental health and chemical dependency services being provided in the NorthSTAR service area. The State also mandates the types of providers and the service array that must be offered and the behavioral health organization ensures provider credentialing. The behavioral health organization performs regular Utilization Management monitoring, as well as periodic provider site and chart reviews.

The provider network selection process is managed by the BHO in close consultation with the local behavioral health authority. The BHO has an open network. On an ongoing basis, interested providers can apply to be in the network. Criteria for network participation are that providers must meet the BHO credentialing criteria, which include a site review process, and agree to the BHO provider contract.

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

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

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

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

2. Details

a. **Scope of Marketing**

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

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

The contract between the State and the NorthSTAR behavioral health organization outlines marketing guidelines that the behavioral health

organization must follow. All marketing materials and activities must be pre-approved by the State, thereby ensuring that enrollees receive accurate, unbiased information about their plan and provider choices. This is monitored through the prior approval process and through review of complaints received by the State. NorthSTAR employs the services of an independent enrollment broker, which has the responsibility for mailing consumer enrollment, and educational materials to Medicaid-eligible individuals and for conducting consumer education and enrollment events. The State has reviewed and approved all informational, marketing and enrollment materials submitted by the contracted behavioral health organization prior to public distribution.

The State tracks complaints related to marketing practices. During the last waiver period the State did not receive any complaints related to behavioral health organization marketing practices/materials. The State did not receive any complaints related to network provider marketing-related issues.

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

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

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

The State permits the behavioral health organization to conduct indirect marketing for the behavioral health organization in general; however, all marketing materials regarding the program or Medicaid in general, including advertising scripts, are subject to prior approval by the State. The behavioral health organization is prohibited from targeting specific types of clients with such marketing and the behavioral health organization must follow all marketing guidelines set by the State regardless of the marketing medium. No marketing may be conducted without prior approval by the State. The behavioral health organization may use any State-approved marketing strategy, which may include, but is not limited to, health seminars, health fairs, community outreach programs, multimedia advertisements, mailers, and billboard advertisements.

Under the NorthSTAR contract, the behavioral health organization may offer nominal gifts valued at no more than \$10 and free health screenings approved by the State to potentially eligible individuals as long as these gifts and free health screenings are offered whether or not the individual enrolls in the behavioral health organization plan. Free health screenings must not be used to discourage less healthy individuals from enrolling in the behavioral health organization's plan. Distribution of such gifts must be pre-approved by the State. The State tracks complaints related to behavioral health organization marketing practices.

3. X 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:

The State has stipulated in the contract that the behavioral health organization may not use marketing agents who are paid solely by commission. Beyond this restriction, the State does not dictate how the behavioral health organization pays their marketing representatives.

An Enrollment Broker employee, and not the behavioral health organization marketing representative, enrolls clients who opt to enroll at enrollment events. Because clients may choose to mail or phone in their enrollment later, it would be difficult for the behavioral health organization to isolate which clients may have joined their plan due to the efforts of a particular marketing representative. The State prohibits coercive or fraudulent marketing practices. The State pre-approves all marketing materials and reviews all complaints. Violations are investigated and appropriate action taken against the party involved.

The State has incorporated specific requirements into the contracts, which prohibit the behavioral health organization from using marketing agents who are paid solely by commission. Furthermore, the State contract contains specific provisions which govern the marketing practices of the behavioral health organization and their marketing representatives, including specific provisions that prohibit them from:

- (a) engaging in marketing or enrollment practices that discriminate because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or requirements for health care services;
- (b) engaging in door-to-door marketing, telephonic, or other "cold-call" marketing;
- (c) conducting face-to-face marketing at public assistance offices;
- (d) making any material misrepresentations to any person regarding the NorthSTAR program, Medicaid, Medical Assistance, or Title XIX;

- (e) offering individuals any an inducement to enroll except for nominal gifts valued at \$10.00 or less. (Distribution of such gifts must be pre-approved by the State);
- (f) seeking to influence an individual's enrollment by linking the behavioral health organization's managed care products with the sale of other insurance products.

The State monitors compliance with these contractual requirements by tracking all complaints related to the behavioral health organization marketing practices. Furthermore, the Local Behavioral Health Authority monitors the behavioral health organization and facilitates the behavioral health organization's interaction with Community Based Organizations, providers, advocates, and consumers.

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

The behavioral health organization is required to ensure that all marketing and enrollment materials are available in the language of any population group that comprises more than ten percent of the covered lives. Currently, the only languages comprising ten percent of the covered lives are English and Spanish. The behavioral health organization must ensure that all written plan materials required to be translated are certified by a professional translator or translation service.

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

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. X The languages comprise all languages in the service area spoken by approximately ten percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The behavioral health organization is required to ensure that all marketing and enrollment materials are available in the language of any population group that comprises more than ten percent of the covered lives. Currently, the only languages comprising ten percent of the covered lives are English and Spanish. The behavioral health organization must ensure that all written plan materials required to be translated are certified by a professional translator or translation service.

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

1. The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
2. The languages spoken by approximately ten percent or more of the potential enrollee/ enrollee population.
3. Other (please explain):

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

NorthSTAR **contract** requires the behavioral health organization to provide 24-hour access to interpreter services for enrollees to access emergency behavioral health services within the behavioral health

organization's network either through telephone language services or interpreters. The behavioral health organization must:

- a) Provide interpreter services for enrollees as necessary to ensure effective communication, including translated written and video materials, documents, forms and information pamphlets regarding behavioral health prevention services, assessment, treatment or education;
- b) Use trained professional interpreters when behavioral health treatment is discussed. Family members or friends may not be used as interpreters in behavioral health treatment;
- c) Have an identified staff member to assist enrollees who are deaf or hard-of-hearing individuals;
- d) Maintain a current list of interpreters who are "on-call" to provide interpreter services and make a copy of the list readily available to the State upon request. This list must include individuals that can competently translate Spanish and provide Level III interpretive sign language services. The behavioral health organization must comply with the Title III of the ADA and have TDDs in offices where the primary means of offering goods and services is by telephone.

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

The State contracts with an enrollment broker to help enrollees and potential enrollees understand the managed care program. The State also contracts with a local behavioral health authority which also provides these services. The State's contracted behavioral health organization also has a prevention/education/outreach department which performs this function. **The service provided by these entities is an educational service. This education consists of description of how the system works, how to choose a network provider, who to contact is a problem is encountered, etc.. Through the educational process provided, enrollees and potential enrollees better understand the system into which they will be enrolled, and therefore confusion is mitigated.**

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- X contractor (please specify) _____

The State's Enrollment Broker, performs outreach activities, conducts enrollment events, and assists clients with enrollment in person and over the phone. Outreach includes notifying clients about the program through publicized events, partnering with community-based organizations to disseminate information about the program, and brochures, flyers and posters in the clients' communities. A newly eligible individual receives an enrollment kit in the mail from the Enrollment Broker. The enrollment kit contains information about NorthSTAR,

including the provider network and instructions for enrolling via mail, over the phone, or at an enrollment event.

If the eligible individual has questions or needs assistance, he or she can contact the Enrollment Broker. If necessary, the Enrollment Broker staff does home visits to help eligible individuals to understand their choices and the enrollment process. Eligible individuals are counseled through a plan information sheet included in enrollment mail-outs, audio and video presentations given in Texas Health and Human Commission (HHSC) eligibility offices, by outreach staff located in the community, and by phone. The Enrollment Broker makes peer counseling and one-on-one counseling available to clients. In addition to the training the Enrollment Broker staff received on the traditional Medicaid population, training on the NorthSTAR population and their special needs is required by the state. The Enrollment Broker contacts community-based organizations and consumer advocacy organizations to provide a critical link between the Enrollment Broker and the NorthSTAR population.

Outreach activities strive to educate consumers on the benefits of managed care, the services available to them, and the process for enrollment, to include assistance with the application process. Staff members at the outreach activities also answer questions the client may have and provide contact information for the client. A partial list of such outreach activities during the months of November 2008-January 2009 includes:

- Grand Prairie – Texas Workforce Commission
- Dallas – Pregnancy Resource center
- Richardson – Workforce Solutions
- Waxahachie – Ellis County Community Resource Coordination Group meeting
- Frisco – Frisco Cares Children’s Clinic
- Plano – Plano ISD Jackson Elementary School
- Garland – WIC program
- Irving – Our Redeemer Lutheran Church
- Greenville – Hunt Inter-agency Meeting
- McKinney – McKinney Workforce Center
- Farmersville – Farmersville Medical Center
- Wilmer – Clayton Crossing Park
- Mesquite – WIC Program
- Ennis – WIC program

The State and the local mental health authority have also engaged in numerous community outreach activities with advocacy organizations, city, county, and state government officials, non-network providers, physical health providers, and organizations.

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

c. Enrollee Information

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

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

The Enrollment Broker assists Medicaid clients enrolling in Medicaid managed care and in selecting managed care options. To perform this function the Enrollment Broker receives a list of Medicaid clients who are to enroll in NorthSTAR. The Enrollment Broker then provides education and enrollment materials and activities to assist eligible individuals in understanding managed care and the services and choices available to them under NorthSTAR. The Enrollment Broker provides enrollment materials through the mail and processes all enrollment requests. The Enrollment Broker operates the information interfaces required both to record enrollment decisions in System for Application, Verification, Eligibility, Reports and Referrals, the State’s Medicaid eligibility system, and provides a list of enrollees to the behavioral health organization.

The Enrollment Broker also provides corresponding services with respect to the ongoing enrollment, disenrollment, and re-enrollment activity of eligible individuals. The Enrollment Broker maintains a help line to enroll eligible individuals and to respond to inquiries relating to the administration of managed care programs.

C. Enrollment and Disenrollment

1. Assurances.

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

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

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

submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

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

The State, Local Behavioral Health Authority, and the behavioral health organization work in conjunction to ensure adequate outreach efforts to the communities in all seven counties in the NorthSTAR service delivery area. As part of its duties, the Local Behavioral Health Authority conducts outreach activities with the local providers, consumers, and family members.

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: Maximus, Inc.

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

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

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

- ___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):
- ___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):
- X If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

The State was granted permission by CMS to operate with a single contracted behavioral health organization with the approval of the waiver submission beginning October 1, 2005. The State further requests CMS permission to continue to operate with a single contracted behavioral health organization for the duration of the waiver period beginning October 1, 2009, ending September 30, 2011.

The State intends on issuing a request for proposal in state fiscal year 2010, for contract implementation in state fiscal year 2012. It is the intent of the State to procure two behavioral health organizations if possible. It was not the intent of the State to change the rationale for operating under one BHO, and all efforts will be made to secure two BHOs for the program.

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

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

- ___ The State provides **guaranteed eligibility** of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- ___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
- X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

- ___ 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.

The State was granted permission by CMS to operate with a single contracted behavioral health organization with the approval of the waiver submission beginning October 1, 2005. The State further requests CMS permission to continue to operate with a single contracted behavioral health organization for the duration of the waiver period beginning October 1, 2009, and ending September 30, 2011.

The State intends on issuing a request for proposal in state fiscal year 2010, for contract implementation in state fiscal year 2012. It is the intent of the State to procure two behavioral health organizations if possible. It was not the intent of the State to change the rationale for operating under one BHO, and all efforts will be made to secure two BHOs for the program.

- 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. All Medicaid enrollees who lose Medicaid eligibility and regain their eligibility within 180 days will be automatically re-enrolled in the single behavioral health organization.

X The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply: The behavioral health organization may request disenrollment of a Medicaid eligible enrollee against his or her will under limited conditions. These conditions include, but are not limited to:

- (a) Severe disruptive behavior not caused by a behavioral health condition at a network provider's office;
- (b) Fraudulent loaning of the enrollee's Medicaid identification card to another person

The behavioral health organization may not request a disenrollment based on any of the following:

- (a) An adverse change in the enrollee’s health or behavioral health status;
- (b) Utilization of medically necessary services;
- (c) Enrollee’s race, color, national origin, sex, age, disability, political beliefs or religion, or
- (d) Enrollee's disruptive behavior is due to a behavioral health or physical health condition.

Prior to exercising a right to disenroll an enrollee, the behavioral health organization must:

Document that necessary steps have been taken to educate the enrollee regarding the conditions for disenrollment. If an enrollee exhibits disruptive behavior, the behavioral health organization must work with the enrollee and his family, as appropriate, to develop a plan to address the disruptive behavior prior to requesting disenrollment of the enrollee. **Although this has historically been handled through consultations with enrollees and has not resulted in actual disenrollment, if it should occur, these individuals**

would be able to receive their behavioral healthcare through the traditional Medicaid fee for service system.

- i. ___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
- ii. X The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. ___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. ___ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

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

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

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

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

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

E. Grievance System

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

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

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

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

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

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

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

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

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing. **Based on the NorthSTAR program staffs' understanding of the Medicaid Fair Hearing**

provisions, NorthSTAR can require Medicaid enrollees to exhaust the PIHP appeals process before requesting a 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 90 days (between 20 and 90).

The State's timeframe within which an enrollee must file a **grievance** is ___ days.
The State does not establish a timeframe for an enrollee to file a complaint.

c. Special Needs

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

NorthSTAR serves a vulnerable specialty population. During the early design phase of the program, the State determined that it was essential that special protections be put in place to ensure that consumers were able to receive assistance in advocating for themselves. To that end the State created and supports an independent Local Behavioral Health Authority which has as one of its primary functions the provision of advocacy ombudsman services to consumers and families.

Because the Local Behavioral Health Authority does not provide treatment services and is not affiliated with or dependent upon the behavioral health organization, it can speak without bias on behalf of consumers. Because the Local Behavioral Health Authority is easily accessible to consumers and because it exists solely for the purpose of giving consumers and concerned citizens a voice in how managed care is delivered, it is "consumer friendly." The Local Behavioral Health Authority also has close working relationships with local consumer advocacy groups which enables it to readily assist consumers with special needs.

The State has also worked to ensure that consumers have a number of avenues for filing complaints including, but not limited to, filing directly with the behavioral health organization, filing through the Local Behavioral Health Authority, filing directly with the NorthSTAR office, filing through a toll-free managed care

complaint line, and filing with the consumer rights office of the Department of State Health Services

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 procedure is operated by:

- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

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

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

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

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

___ Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process_____

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

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

___ Other (please explain):

F. **Program Integrity**

1. **Assurances.**

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

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

The prohibited relationships are:

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

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

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

2. Assurances For MCO or PIHP programs

- X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, and Timing of Certification.
- ___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	Primary Care Physician/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data	X	X	X	X	X	X	X	X	X	X	X	X
Data Analysis (non-claims)	X	X	X	X	X	X	X	X	X	X	X	X
Enrollee Hotlines	X	X	X	X	X	X	X	X	X	X	X	X
Focused Studies												X
Geographic mapping	X							X		X	X	
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups								X			X	X
Network Adequacy Assurance by Plan	X						X	X	X	X	X	

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	Primary Care Physician/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Ombudsman	X	X	X	X	X	X	X	X	X	X	X	X
On-Site Review	X	X	X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects												X
Performance Measures							X		X			X
Periodic Comparison of # of Providers	X				X			X		X	X	
Profile Utilization by Provider Caseload								X			X	X
Provider Self-Report Data							X	X	X	X		X
Test 24/7 Primary Care Physician Availability												
Utilization Review									X	X	X	X
Other: (describe)												

II. Details of Monitoring Activities

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

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

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

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

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

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

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

c. Consumer Self-Report data

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

Program: NorthSTAR

Personnel responsible: State agency (HHSC)

Description of activity: Consumer self-report satisfaction survey (Adult and Child/Adolescent)

Frequency: Annual

How it yields information: Provides information on access to services, participation in treatment, cultural sensitivity, satisfaction, and outcome.

- d. X Data Analysis (non-claims)
 ___ Denials of referral requests
 ___ Disenrollment requests by enrollee
 ___ From plan
 ___ From PCP within plan
 X Grievances and appeals data
 ___ PCP termination rates and reasons
 X Other (please describe)
 Applicable programs: NorthSTAR
 Personnel responsible: Department of State Health Services staff.
 Detailed description of activity: Regular and Special analysis of utilization/outcome, adverse determination/appeal, complaint and network adequacy data. Regular publication of this data in reports for State-level staff and stakeholders
 Frequency of use: Daily
 How it yields information about the area(s) being monitored: Assists the State in determining if Program's goals are being met.
- e. X Enrollee Hotlines operated by State
 Applicable programs: NorthSTAR.
 Personnel responsible: behavioral health organization, Local Behavioral Health Authority, State of Texas Access Reform Link (Medicaid Helpline), State (Consumer Services and Rights Protection)
 Detailed description of activity: Established toll-free numbers to assist enrollees and prospective enrollees in understanding NorthSTAR and to assist in resolution of complaints.
 Frequency of use: Daily.
 How it yields information about the area(s) being monitored: All complaint information received by the hotlines is compiled into an overall report for analysis of trends.
- f. X Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
 Program: NorthSTAR.
 Personnel responsible: External Quality Review Organization, Contracted behavioral health organization
 Description of activity: Analysis of certain aspects of clinical. or non-clinical services for selected target populations.
 Frequency: Determined by contractual requirements.
 How it yields information: Provides defined answers to study questions at a given point in time.

- g. X Geographic mapping of provider network
 Applicable programs: NorthSTAR.
 Personnel responsible: behavioral health organization (report delivered to State and Local Behavioral Health Authority)
 Detailed description of activity: the behavioral health organization provides quarterly geographical access reports of provider network. State staff and the Local Behavioral Health Authority staff periodically reviews these reports for network adequacy.
 Frequency of use: Quarterly.
 How it yields information about the area(s) being monitored: Among other tools, it enables the State staff and the Local Behavioral Health Authority staff to assess the behavioral health organization's network adequacy.
- h. _____ Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)
- i. X Measurement of any disparities by racial or ethnic groups
 Applicable programs: NorthSTAR.
 Personnel responsible: Department of State Health Services staff.
 Detailed description of activity: Regular data analysis on service utilization by racial/ethnic groups.
 Frequency of use: Quarterly (in data book).
 How it yields information about the area(s) being monitored: Informs NorthSTAR staff, the Local Behavioral Health Authority staff, and stakeholders on enrollee utilization by race/ethnicity.
- j. X Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]
 Applicable programs: NorthSTAR.
 Personnel responsible: Department of State Health Services staff and behavioral health organization staff.
 Detailed description of activity: Monthly monitoring of provider network change reports and review of provider directories.
 Frequency of use: Monthly.
 How it yields information about the area(s) being monitored: Helps staff determine net changes in provider network over time. Allows the State to better assess capacity/adequacy of provider network.
- k. X Ombudsman
 Applicable program: NorthSTAR
 Personnel responsible: Local Behavioral Health Authority
 Description of activity: Assistance/investigation for consumers regarding complaints and/or other issues of concern.
 Frequency: Ongoing.
 How it yields information: Provides ongoing information about programmatic problems and methods of achieving equitable settlements.

- l. X On-site review
 Program: NorthSTAR
 Personnel responsible: Department of State Health Services staff
 Description of activity: Review of plan’s clinical and administrative procedures and compliance with contractual requirements.
 Frequency: Once each waiver cycle-Every two years.
 How it yields information: Verifies contractual compliance and identifies areas for improvement or corrective action, if necessary.
- m. X Performance Improvement projects [Required for MCO/PIHP]
 X Clinical
 X Non-clinical
 Program: NorthSTAR
 Personnel responsible: behavioral health organization
 Description of activity: Investigation of significant aspects of clinical care and non-clinical functions
 Frequency: Determined by contractual requirements
 How it yields information: Provides opportunity to verify demonstrable and sustained improvement in selected areas of study
- n. X Performance measures [**Required** for MCO/PIHP]
 Process
 Health status/outcomes
 Access/availability of care
 Use of services/utilization
 Health plan stability/financial/cost of care
 Health plan/provider characteristics
 Beneficiary characteristics
- Applicable programs: NorthSTAR.
 Personnel responsible: Department of State Health Services staff, behavioral health organization staff.
 Detailed description of activity: Through a variety of data (encounter/enrollment/provider network data), the State staff and the behavioral health organization continuously monitor the above outcomes. The State analyzes these data on a regular basis. This ongoing analysis, coupled with continuous involvement in the behavioral health organization quality improvement process, active participation in provider/consumer forums, as well as contractually established performance indicators, allows the State to monitor these measures, require behavioral health organization’s to take corrective action in real time.
 Frequency of use: Ongoing.
 How it yields information about the area(s) being monitored: This ongoing analysis, coupled with continuous involvement in the behavioral health organization quality improvement process, active participation in

provider/consumer forums, as well as contractually established performance indicators, allows the State to monitor these measures and require the behavioral health organization to take corrective action in real time.

- o. X Periodic comparison of number and types of Medicaid providers before and after waiver
Applicable programs: NorthSTAR.
Personnel responsible: Department of State Health Services staff.
Detailed description of activity: Analysis of numbers of Medicaid Significant Traditional Providers before and after NorthSTAR implementation.
Frequency of use: This activity has not been done in this waiver period, as the network has not substantively changed.
How it yields information about the area(s) being monitored: Measures stability of network.

- p. X Profile utilization by provider caseload (looking for outliers)
Applicable programs: NorthSTAR.
Personnel responsible: Department of State Health Services staff, behavioral health organization staff.
Detailed description of activity: Regular data analysis which evaluates caseloads and payments to providers (by service type) to determine possible over/underutilization. Also monitors fiscal stability of providers.
Frequency of use: Monthly.
How it yields information about the area(s) being monitored: Determine possible over/underutilization. Also monitors fiscal stability of providers.

- q. X Provider Self-report data
 Survey of providers
 Focus groups
 X Other

Regular attendance at behavioral health organization and Provider meetings and trainings.

Applicable programs: NorthSTAR.

Personnel responsible: Department of State Health Services staff, behavioral health organization staff.

Detailed description of activity: State staff regularly participates in the behavioral health organization provider meetings (at least twice monthly).

This ongoing participation allows the State to effectively evaluate/troubleshoot providers' perspectives and experiences in the program.

Frequency of use: At least twice monthly.

How it yields information about the area(s) being monitored: This ongoing participation allows the State to effectively evaluate/troubleshoot provider's perspectives and experiences in the program.

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

- s. X Utilization review (e.g. ER, non-authorized specialist requests)
Applicable programs: NorthSTAR.
Personnel responsible: Department of State Health Services staff.
Detailed description of activity: Monitor authorization processes.
Frequency of use: Annually.
How it yields information about the area(s) being monitored: Assures compliance with contractual authorization mandates and established clinical criteria.

- t. X Other: (please describe)
Program: NorthSTAR.
Personnel responsible: Local Behavioral Health Authority
Description of activity: Consumer self report satisfaction survey (Adult and Youth).
Frequency: Periodic.
How it yields information: Provides information on access, quality/appropriateness of services, satisfaction, and outcomes.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request.

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

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

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

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

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

Strategy: Availability Standards monitoring

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

I. Timely Access Standards

Strategy: Availability standards monitoring.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: Ongoing analysis of provider network reports and GEO-access reports indicate that the behavioral health organization has maintained compliance with access standards throughout the waiver period

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

Strategy: Appointment scheduling monitoring.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: The behavioral health organization is contractually required to ensure timely access to appointments and currently has procedures in place to monitor this. Any problems are primarily monitored through the behavioral health organization's and the Local Behavioral Health Authority's periodic site review process as well as the complaint process.

Problems identified: Between November 2007 to January 2009, the State recorded 13 enrollee complaints for the waiver period involving appointment scheduling. All of these complaints were addressed in a timely manner. The volume of enrollee complaints involving appointment scheduling was extremely low given the number of Medicaid enrollees served in that period (13 of 23,850 equals 0.1 percent) and thus does not indicate significant problem in this area.

Corrective action (plan/provider level): No corrective action plan noted. State and the behavioral health organization will continue to monitor and take corrective action as needed. The behavioral health organization and State hold monthly meetings with providers in an effort to identify/correct any problems.

Program change (system-wide level): None.

Strategy: **Monitoring in-office waiting times.**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: The behavioral health organization is contractually required to ensure that in-office waiting times are not excessive, and the behavioral health organization and NTHBA currently have procedures in place to monitor this. Any problems are primarily monitored through the behavioral health organization's periodic site review process as well as the complaint process.

Problems identified: Between November 2007 to January 2009, the State recorded 19 enrollee complaints for the waiver period involving in-office waiting times. All of these complaints were addressed in a timely manner. The volume of enrollee complaints involving excessive in-office waiting times was extremely low given the number of Medicaid enrollees served in that period (19 of 23,850 equals 0.1 percent), and thus does not indicate significant problem in this area.

Corrective action (plan/provider level): No corrective action plan noted. State and the behavioral health organization will continue to monitor for problems and take corrective action as needed.

Program change (system-wide level): None.

II. Access and Availability Monitoring

Strategy: **Access and availability monitoring through tracking/trending complaint/appeal reports, monitoring of call center data, on-site visits, test calls, as well as independent assessment.**

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: Through the strategies mentioned above, the State did not find significant problems in the area of access and availability. The average monthly volume of access related complaints was 11 per month. Given the total annual number of Medicaid clients served (132 of 23,850 equals 0.6percent), and thus does not indicate a significant problem in this area. All complaints/appeals were addressed in a timely manner. Analysis of monthly behavioral health organization call center data did not reveal any issues with call center response times or wait times. The State on-site visit in May 2006 did not reveal any issues that required follow up or corrective action by the behavioral health organization. **This was the last formal onsite review. The state is planning on doing a multi-day onsite review in the fall of 2009.**

The state's relationship with the contract BHO is such there are at least monthly onsite visits with the BHO by separate staff to discuss operational issues and to review processes (UM, QM, customer service, provider relations, IT systems, etc). In addition to these visits, the state attends several monthly

provider and other stakeholder meetings where operational and programmatic issues are discussed and vetted. Each week the state, local behavioral health authority and BHO have conference calls to discuss other prominent program issues. These interfaces, coupled with ongoing monitoring of encounter data and a comprehensive system for capturing, tracking and resolving provider and enrollee complaints and appeals, ensures that the state is in a rigorous and comprehensive oversight role.

Problems identified: Few problems identified, but were addressed in a timely manner.
Corrective action (plan/provider level): No corrective action plan noted. State and the behavioral health organization will continue to monitor using the strategies indicated above.

Program change (system-wide level): None

III. Capacity Standards

Strategy: Capacity standards monitoring through ongoing monitoring provider network change reports and geo access maps, as well as monitoring of complaints and appeals.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: Ongoing analysis of provider network reports and geo-access reports indicate that the behavioral health organization has maintained compliance with access standards throughout the waiver period. The size/capacity of provider network has remained stable over waiver period. The average monthly volume of access related complaints 11 per month. Given the total annual number of Medicaid clients served (132 of 23,850 equals 0.6 percent), and thus does not indicate a significant problem in this area. All complaints/appeals were addressed in a timely manner.

Problems identified: No significant problems identified.

Corrective action (plan/provider level): No corrective action plan noted. State and the behavioral health organization will continue to monitor for problems and take corrective action as needed.

Program change (system-wide level): None.

IV. Capacity Monitoring

Strategy: Network capacity monitoring through ongoing analysis of provider network reports and geo-access reports, as well as monitoring of complaints and appeals.

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results: Ongoing analysis of provider network reports and geo-access reports indicate that the behavioral health organization has maintained compliance with access standards throughout the waiver period. Size/capacity of provider network has

remained stable over waiver period. The average monthly volume of access related complaints were 11 per month. Given the total annual number of Medicaid clients served (132 of 23,850 equals 0.6 percent), and thus does not indicate a significant problem in this area. All complaints/appeals were addressed in a timely manner.

Problems identified: No significant problems identified.

Corrective action (plan/provider level): No corrective action plan noted. State and the behavioral health organization will continue to monitor for problems and take corrective action as needed.

Program change (system-wide level): None

V. Coordination and Continuity of Care Standards

Strategy: Primary Care and Coordination.

Confirmation it was conducted as described:

Yes

No

Summary of results: NorthSTAR does not provide primary care health services. The NorthSTAR behavioral health organization performs coordination of behavioral health services and physical health care services with State of Texas Access Reform HMOs. Toward this end, the Care Coordination workgroup continue to meet quarterly to review and monitor the implementation of care coordination activities, including the External Quality Review Organization Care Coordination focus study and the behavioral health organization's Care Coordination Quality Improvement Project. The workgroup consists of members from the HMO State of Texas Access Reform plans, the behavioral health organization, the Local Behavioral Health Authority and the State NorthSTAR office. The workgroup addresses general care coordination barriers when identified, as well as plan-specific issues when they occur.

Problems identified: Ongoing need for improved communication/coordination between State of Texas Access Reform providers and the behavioral health organization, and NorthSTAR providers.

Corrective action: The behavioral health organization scheduled information sharing meetings with HMOs will repeat regularly. The behavioral health organization continued to provide training on Texas Health Steps health-screening program in an effort to improve coordination with medical care, and will repeat this training on an ongoing basis.

Program change: The State will monitor the behavioral health organization to ensure periodic meetings occur with HMOs for information/updates on care coordination. The State will monitor ongoing provision of preventive health screening information from the behavioral health organization to providers.

Strategy: Additional services for enrollees with special health care needs.

Confirmation it was conducted as described:

Yes

No

Summary of results: The behavioral health organization provides a clinical screening for all children who present for services to aid the clinician in determining the best treatment alternative. Individuals with multiple or complex needs are referred to a Specialty

Provider Network when clinically indicated. Standardized assessments then target behavioral symptomology and functional deficits.

Additionally, the Enrollment Broker provides training to NorthSTAR enrollment counselors that are designed to highlight the needs of this special population with emphasis on communication with individuals with special needs. Other resources for children and adults with complex needs are the Community Resource Coordination Groups, multi-agency groups that work toward locating and coordinating services not available through NorthSTAR. Referrals are made through the Local Behavioral Health Authority.

Problems identified: Enrollees with special health care needs require more comprehensive services.

Corrective action: The State will continue to require the behavioral health organization to work with Specialty Provider Network providers and other community agencies to ensure a wide service array to meet the needs of this population.

Program change: State will monitor frequency and intensity of services for enrollees with special health care needs utilizing data gathered from the implementation of the Resiliency & Disease Management model.

VI. Coordination and Continuity of Care Monitoring

***Strategy:* The State ensures that the State of Texas Access Reform HMO/NorthSTAR programs continue to improve care coordination through policy and operations**

Confirmation it was conducted as described:

Yes

No

Summary of results: The Care Coordination workgroup (behavioral health organization, State of Texas Access Reform HMOs, Local Behavioral Health Authority, and State staff) met quarterly during this waiver period to address identified issues related to coordination of care and to resolve service barriers. The workgroup has established coordination mechanisms between the behavioral health organization and the State of Texas Access Reform HMOs to help assure that policies and protocols are in place to facilitate this process. Additionally, the group was instrumental in providing input for the most recent behavioral health organization Care Coordination performance improvement study, which is described later in this section.

Problems identified: Ongoing need for timely communication/coordination.

Corrective action: The behavioral health organization schedules information sharing meetings periodically with HMO staff. The behavioral health organization conducts ongoing provider training on physical health screening programs to improve coordination with medical care providers.

Program change: State will direct the behavioral health organization to hold regularly scheduled meetings with the HMO staff and the Specialty Provider Network providers to determine specific procedures to enhance program education.

***Strategy:* The State is a participant in the Regional Advisory Committee (RAC).**

Confirmation it was conducted as described:

Yes

No

Summary of results: Among the committee members are staff from HHSC, the enrollment broker, the State of Texas Access Reform HMOs, the behavioral health organization, the NorthSTAR Local Behavioral Health Authority, the State NorthSTAR office, and various community-based service providers. One of the tasks accomplished by this interagency workgroup has been to identify and address care coordination-related issues.

Problems identified: Problematic issues regarding the coordination of care between physical and behavioral health services continue to occur.

Corrective action: Participating agencies share information and policies to resolve issues.

System change: N/A

Strategy: The State tracks complaint trends or patterns to identify and correct problems related to care coordination and/or continuity of care.

Confirmation it was conducted as described:

Yes

No

Summary of results: Monthly complaint reports submitted by the behavioral health organization and the Local Behavioral Health Authority were tracked and trended by the State. Reports from the Local Behavioral Health Authority were reviewed and any local issues related to care coordination identified. Additionally, a workgroup was formed to improve service coordination for continuity of care with regard to discharge planning at Terrell State Hospital. The workgroup meets quarterly or more often if needed.

Attendees include the behavioral health organization, State hospital Care Managers, community-based providers, hospital social work staff, Local Behavioral Health Authority staff, and the State NorthSTAR Mental Health and Substance Abuse Quality Coordinator. Physical healthcare needs for patients being discharged will be considered if necessary and coordinated with the appropriate medical referrals.

Problems identified: Periodic complaints occur related to care coordination and/or continuity of care.

Corrective action: Additional technical assistance provided to the behavioral health organization and Local Behavioral Health Authority regarding care coordination and/or continuity of care issues.

System change: State will attend discharge planning meetings at Terrell State Hospital and monitor disposition of problematic cases.

Strategy: Behavioral Health Organization Quality Improvement Project: NorthSTAR Care Coordination for Children 2008

Confirmation it was conducted as described:

Yes

No

Summary of results:

Purpose

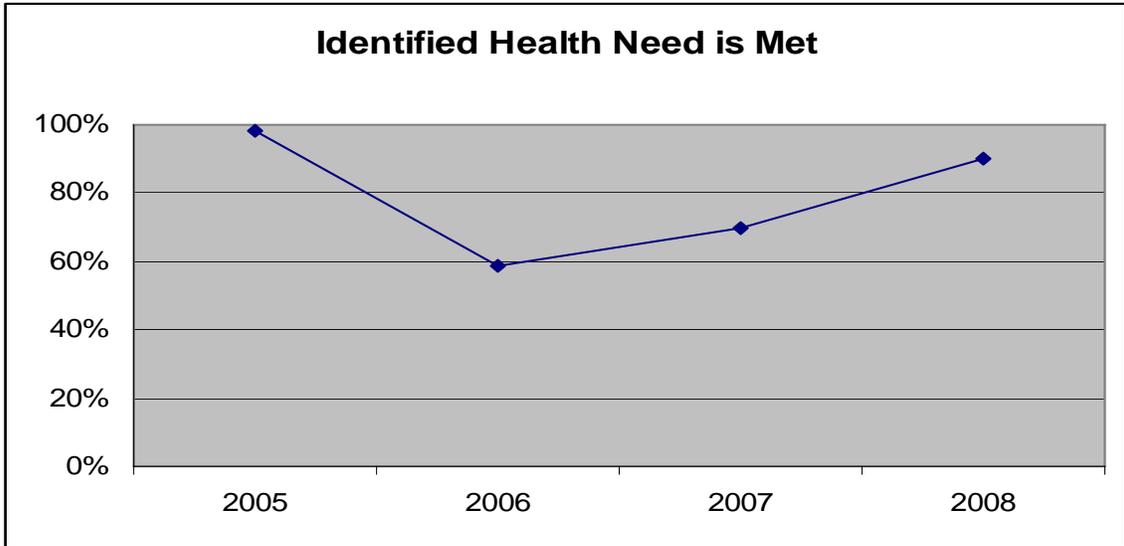
The purpose of this study was to increase Texas Health Steps participation and coordination of physical health needs among NorthSTAR enrollees under the age of 18. NorthSTAR Specialty Provider Networks provide services for children were selected for a medical records audit to assess for medical coordination and promotion of Texas Health Steps examinations. The 2008 study included 100 children and adolescents.

This study continues the efforts begun in 2004 to focus on this population and on these key treatment indicators. The original study was completed by the Institute for Child Health Policy (ICHP), the External Quality Review Organization for Texas. The timeframe for this study was September 1, 2002 through August 31, 2003. Two comparison groups were used to compare NorthSTAR results against these groups. This study examined access to Primary Care Physicians and the receipt of well visits. In the original study, both NorthSTAR children and the two comparison groups achieved over **90** percent of children seeing a Primary Care Physician. This study revealed that implementing strategies to promote routine preventive care for children might benefit children in the NorthSTAR program. Study results were initially presented in the July 27, 2004, Care Coordination Committee meeting and shared with the Medicaid health plans as well as NorthSTAR and the behavioral health organization Quality and Clinical staff.

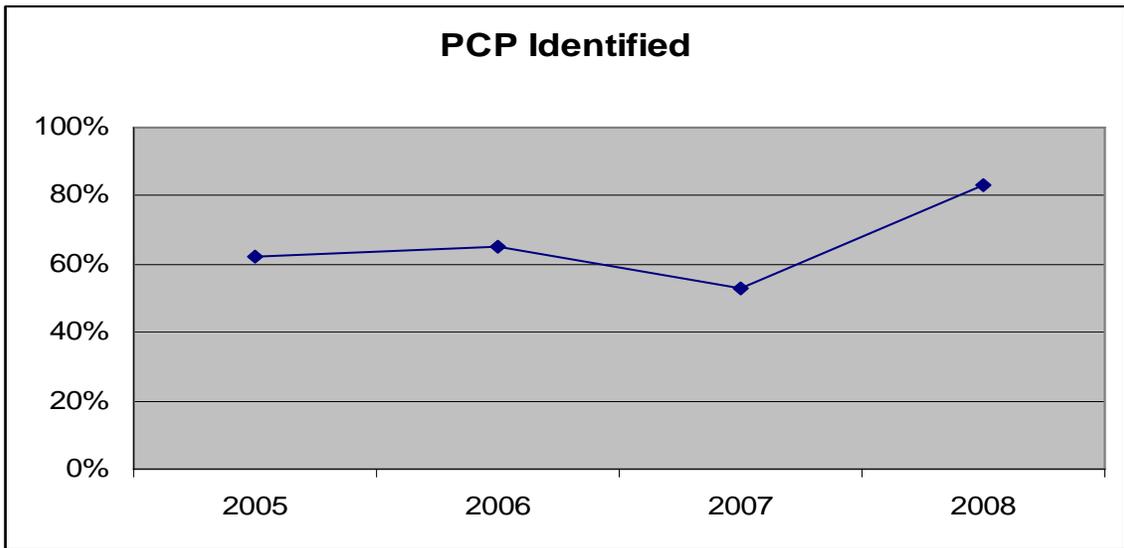
Summary of the Improvement

The outcome from the 2008 study is graphed out below by each element. The two elements “Identified Health Need” and “Medicaid” are for population analysis purposes only. The enrollees were not selected based on either of these criterias, however, to better understand the scores of the other elements these two elements are listed. The five (5) remaining elements are the most significant in terms of showing Texas Health Steps participation and coordination of healthcare.

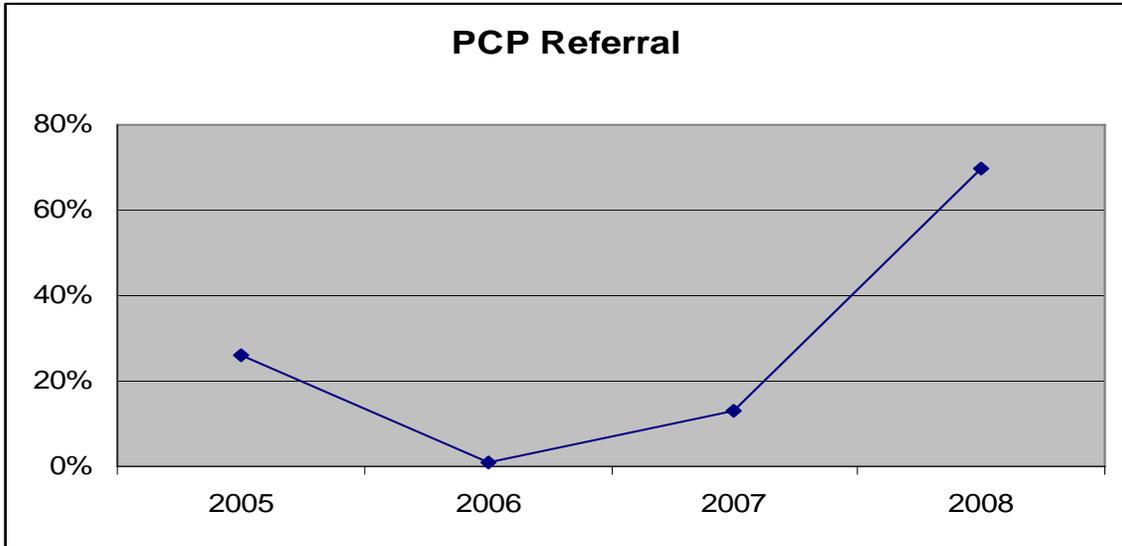
The element of Identified Health Need Met continued being a strong item in 2008. This measure evidences what percentage of the time an identified health was met by coordinating physical healthcare, making referrals or some other type of meaningful intervention.



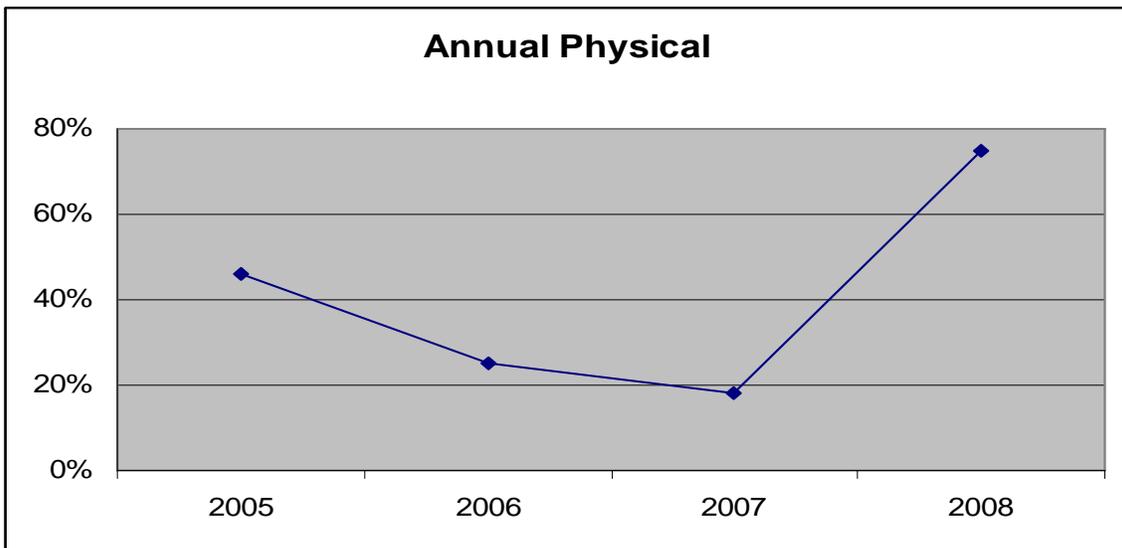
The element of Primary Care Physician Identified has been a consistent element. This measure evidences what percentage of the time all enrollees sampled has an identified Primary Care Physician, by name, within the last twelve (12) months. From 2007 to 2008 this element improved by 30 percent



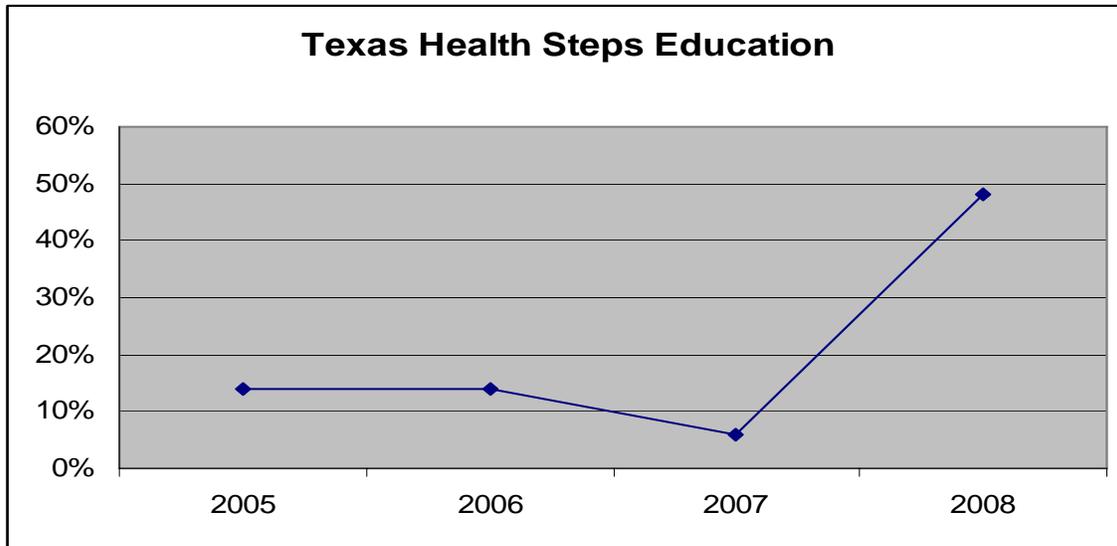
The element of Primary Care Physician Referral has also improved greatly over previous years. This measure evidences what percentage of the time an enrollee was referred to their Primary Care Physician or to a clinic that offers Primary Care Physician services when such services appear to be medically necessary.



The element of Annual Physical has improved 57 percent since it was measured in 2007. This measure evidences what percentage of the time all enrollees sampled has an annual physical within the last twelve (12) months.



The element of Texas Health Steps Education has made a dramatic improvement with a score of 48 percent in 2008. This measure evidences what percentage of the time Medicaid enrollees were educated about the benefits of Texas Health Steps. This education could be in the form of individual or group discussion and/or the handing out of Texas Health Steps brochures and flyers. The Texas Health Steps education is a marked improvement over previous years when the scores were 14 percent (2005), 14 percent (2006) and 6 percent (2007).



Reasons Attributed to the Improvement

- Continued emphasis on the care coordination elements throughout the year at meetings such as the Specialty Provider Network Meeting, Specialty Provider Network Quality Meeting and other provider settings may have influenced the results of the latest scores.
- The methodology change in auditing for 2008 may have attributed to some improvement. Providers participated in the 2008 audit as an intervention to provide enhanced hands on education, by having providers score their medical records against the criteria and then submit the supporting documentation along with the audit tool. This created several questions from providers that clarified the purpose and elements of the audit which may not have been as clearly communicated in earlier years as thought.

Problems identified: Although there was overall improvement from the last study, there remains an ongoing need for improved coordination of care between physical and behavioral health providers.

Corrective action: The behavioral health organization will continue with provider audits and will continue to work with Specialty Provider Network providers to develop best practice procedures for ensuring that members are educated at regular intervals about physical health benefits available to them, and that documentation that this has been done is present in the medical record.

Program change: State will monitor the behavioral health organization audit results, as well as best practice procedures for providers. State will monitor to ensure that the behavioral health organization is providing preventative health promotion training and brochures at Specialty Provider Network provider meetings.

Over the 10-year evolution of the NorthSTAR program, the State has developed increasingly in-depth and sophisticated monitoring strategies in collaboration with the BHO and the LBHA. Improved outcomes have been noted over time as a result

of these strategies, and we continually strive to mitigate barriers as they occur. Each waiver period has presented us with the opportunity to work with our partners (the BHO, the LBHA, and other involved stakeholders) toward the mission of providing the best possible services to our enrollees and to our communities. We will continue to use our existing monitoring strategies and to develop new ones in order to maintain the trend toward improved outcomes.

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

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

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances: Thomas Suehs
- c. Telephone Number: (512)424-6526
- d. E-mail: thomas.suehs@hhsc.state.tx.us
- e. The State is choosing to report waiver expenditures based on X date of payment.
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding four years) upon the second renewal and thereafter.

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

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

Enrollees in NorthSTAR are also eligible for enrollment in STAR 1915(b) and the Department of Aging and Disability Services home and community based services program 1915(c) waivers (ICM, CLASS, HCS, TxHmL).

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

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

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

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

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

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

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

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

- a. ___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 - 1. ___ First Year: \$ ___ per member per month fee
 - 2. ___ Second Year: \$ ___ per member per month fee
 - 3. ___ Third Year: \$ ___ per member per month fee
 - 4. ___ Fourth Year: \$ ___ per member per month fee
- b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ___ Other reimbursement method/amount. \$ _____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a. ___ Population in the base year data
 - 1. ___ Base year data is from the same population as to be included in the waiver.
 - 2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. ___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

- d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____
- e. ___ [Required] List the year(s) being used by the State as a base year: _____. If multiple years are being used, please explain: _____
- f. ___ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. ___ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
For R2, there were only three months of certified data available – 10/1/08 through 12/31/08. Therefore for R2, the spreadsheets only contain three months' worth of member months and actual paid cost. The trend rates on Appendix D5 were applied to the 16.5-month period of time from the midpoint of the abbreviated R2 to the midpoint of P1 using the annualized trend rate, adjusted for the 16.5 month time period. For the 12-month time period from the midpoint of P1 to the midpoint of P2, the annualized trend rate was applied.

c. X [Required] Explain the reason for any increase or decrease in member months projections from the base or retrospective year or over time:
Population projections for the Dallas area have shown increases for future periods. Medicaid recipient months are trended forward using Commissioner approved trends by risk group for FY 2008 and FY 2009. The Dallas area is projected using the Dallas area proportion of the statewide forecast. Medicaid Caseload has been growing, especially in the children's groups and in the Disabled and Blind (D&B) groups.

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

e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
The previous application was a renewal waiver, which changed the waiver period to the federal fiscal year and used Medicaid funds according to the waiver periods previously approved by CMS. The waiver periods changed in the approval letter for the last waiver cycle and HHSC has conformed to the last approved waiver cycle. The retrospective year 1 is October 1, 2007 through September 30, 2008, and retrospective year 2 is October 1, 2008 through September 30, 2009. These years coincide with the federal fiscal year.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5. Explain the differences here and how the adjustments were made on Appendix D5:

The service array in this renewal application is the same as previous waiver submissions.

b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:
Behavioral health services from the state plan are included in the waiver. Additionally, the state plan pharmacy services in the Dallas area are covered under a separate program addressed in the State of Texas Access Reform waiver. This waiver and the State of Texas Access Reform waiver both cover the Medicaid population in the Dallas area, but each program collects its own costs and contracts with separate entities for separate services.

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

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial*

programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, External Quality Review Organization, Enrollment Broker- See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 per member per month</i>	<i>9.97 percent or \$5,411</i>	<i>\$59,675 or .03 per member per month P1 \$62,488 or .03 per member per month P2</i>
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

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

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. ___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. X Other (Please explain).
The state allocates the administrative costs to the behavioral health managed care program, based upon the weighted costs of unduplicated NorthSTAR recipient months as a percentage of the total Medicaid recipient months. These percentages are applied to individual cost categories within the total allocation amount, as applicable to the NorthSTAR program.

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 per member per month</i>	<i>9.97 percent or \$5,411</i>	<i>\$59,675 or .03 per member per month P1 \$62,488 or .03 per member per month P2</i>
Total	(per member per month in Appendix D5 Column T x projected member months should correspond)		(per member per month in Appendix D5 Column W x projected member months should correspond)

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

amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,751,500 or \$.97 per member per month R1</i> <i>\$1,959,150 or \$1.04 per member per month R2 or BY in Conversion</i>	<i>8.6 percent or \$169,245</i>	<i>\$2,128,395 or 1.07 per member per month in P1</i> <i>\$2,291,216 or 1.10 per member per month in P2</i>
Total	(per member per month in Appendix D3 Column H x member months should correspond)		(per member per month in Appendix D5 Column W x projected member months should correspond)

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

renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

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

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

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

Current Initial Waiver Adjustments in the preprint

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

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments):

States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

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

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

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

technology, practice patterns, and/or units of service per member per month.

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

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

Others:

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

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

2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

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

For each change, please report the following:

A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____

- B. ___ The size of the adjustment was based on pending SPA.
Approximate per member per month size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA.
per member per month size of adjustment _____
- D. ___ Other (please describe):
- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
per member per month size of adjustment _____
 - D. ___ Other (please describe):
- iv. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
per member per month 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). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA.
Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA.
per member per month size of adjustment _____
 - D. ___ Other (please describe):
- c. ___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time*

administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

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

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual

Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 2. ___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.
1. ___ We assure CMS that GME payments are included from base year data.
 2. ___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
 3. ___ Other (please describe):
- If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.
1. ___ GME adjustment was made.

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

Method:

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

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

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

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

Basis and Method:

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

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

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

2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

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

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

Basis and method:

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

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

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5.**
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3. ___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under “Other” including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

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

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

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

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

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

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing

FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the per member per month Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM per member per month Actual Waiver Cost will subtract out of the equation: Per member per month Waiver Cost Projection – per member per month Actual Waiver Cost = per member per month Cost-effectiveness).

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use

recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.

1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 2. ___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 3. ___ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 2. ___ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess upper payment limit is phased out, CMS will no longer match excess institutional upper payment limit 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 percent of the institutional upper payment limit in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

- a. X **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: 5.6%. Please document how that trend was calculated: **Source: Dallas Area data May 2009. Updated actual annual member months for SSI: R2 796,007, for TANF: R2 3,414,289. Trend for R2 to P1 based upon actual annual member months is 5.6 percent.**

The raising of therapeutic amounts and outreach are programmatic changes, and are not included in other administrative changes as noted in the State historical cost increases. The administrative cost only apply to salaries, benefits, travel, and general administrative cost for state staff such as legal, accounting, payroll, eligibility, rate

setting, etc. based on either the cost allocation plan factors or the indirect cost rate of the state agency.

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) (*i.e., trending from present into the future*).

i. X State historical cost increases. Please indicate the years on which the rates are based: base years **FY 2000 to FY2008** 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 per member per month.

The trend of five percent is a general average over five or more years adjusting for known anomalies. The trend includes price and utilization changes as well as other factors such as technology that would influence an average per person. The state has raised the minimum therapeutic amount of services for individuals needing routine mental health services, as well as required increased outreach and access to crisis and acute services. These requirements will increase service utilization and costs. For R2, there were only three months of certified data available – 10/1/08 through 12/31/08. Therefore for R2, the spreadsheets only contain three months' worth of member months and actual paid cost. The trend rates on Appendix D5 were applied to the 16.5-month period of time from the midpoint of the abbreviated R2 to the midpoint of P1 using the annualized trend rate, adjusted for the 16.5 month time period. For the 12-month time period from the midpoint of P1 to the midpoint of P2, the annualized trend rate was applied.

ii. National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs.

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service per member per month.

The State Plan inflation rate assumes an increased service penetration for individuals needing mental health services, which will increase service costs.

3.____ The State estimated the per member per month cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The state has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

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

Others:

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

1. X 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 and is listed and described below:
- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. per member per month size of adjustment _____
 - D. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
 - iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. per member per month size of adjustment _____
 - D. ___ Other (please describe):
 - v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate per member per month size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. per member per month size of adjustment _____
 - D. ___ Other (please describe):
 - vi. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). per member per month size of adjustment _____

B. ___ The size of the adjustment was based on pending SPA.
Approximate per member per month size of adjustment _____

C. ___ Determine adjustment based on currently approved SPA.
per member per month size of adjustment _____

D. ___ Other (please describe):

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

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

2. X An administrative adjustment was made.

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

ii. ___ Cost increases were accounted for.

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

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

C. X State Historical State Administrative Inflation. The actual trend rate used is: 2 percent. Please document how that trend was calculated: The State recommended a conservative 2 percent administrative cost adjustment, based on historical average administration cost data

D. X Other (please describe) .

For R2, there were only three months of certified data available – 10/1/08 through 12/31/08. Therefore for R2, the spreadsheets only contain three months' worth of member months and actual paid cost. The trend rates on Appendix D5 were applied to the 16.5-month period of time from the midpoint of the abbreviated R2 to the midpoint of P1 using the annualized trend rate, adjusted for the 16.5 month time period.

For the 12-month time period from the midpoint of P1 to the midpoint of P2, the annualized trend rate was applied.

- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
- A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2. ___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
 - i. State historical 1915(b)(3) trend rates
 - 1. Please indicate the years on which the rates are based: base years _____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
 - ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** _____
 3. Explain any differences:
- f. **Other Adjustments** including but not limited to federal government changes. (Please describe):
- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
 - Once the State's FFS institutional excess upper payment limit is phased out, CMS will no longer match excess institutional upper payment limit 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 percent of the institutional upper payment limit in the cost effectiveness process.
 - ◆ For all other payments made under the upper payment limit, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 - **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
- Basis and Method:*
- 1.____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5.**

2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
 3. ___ Other (please describe):
1. No adjustment was made.
 2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

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

Reference J.a.2.ii and J.c.2.D.

The 6.9 percent is a weighted average, computed by taking 12 percent times the total of pharmacy claims for (R2), plus the six-percent factor times the non-pharmacy related claims, then dividing the sum by the total of all claims during the period (R2).

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. **N/A**

Target projections are based off of R2 data.

M. Appendix D7 - Summary

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

Medicaid recipient months are trended forward using Commissioner approved trends by risk group for FY 2010 and FY 2011. The Dallas area is projected using the Dallas area proportion of the statewide forecast.

Medicaid Caseload has been growing especially in the children's groups and in the disabled and blind group.

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

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

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent

with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J:**

The State did not separately project the cost impact of utilization changes and inflation changes. Trend factors that combine both utilization and inflation components were applied.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I. None**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.