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

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

Facesheet

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

The **State** of Minnesota 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 Minnesota Senior Care Plus (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.

_ x _ 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).

x 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.

Section B is ___ replaced in full

__ carried over from previous waiver period. The State:

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

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

Effective Dates: This waiver/renewal/amendment is requested for a period of five years; effective ~~June~~ October 1, 2024 and ending June 30, 2026. (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 Christina Samion and can be reached by telephone at (651) 431-5885, or fax at (651) 431-7421, or e-mail at christina.samion@state.mn.us (Please list for each program)

Section A: Program Description

Part I: Program Overview

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

Notice of the proposal to renew the waiver and a request for comment was sent to Tribal Chairs and Tribal Health Directors on March 1, 2021. A discussion of the waiver renewal proposal took place at the Tribal Health Director's quarterly meeting on February 18, 2021. A copy of the consultation letter is provided at Appendix B.

On January 17, 2022 a letter, along with a copy of the proposed waiver amendment application, was sent via email to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic requesting their comment on the Minnesota Department of Human Services' request to the Centers for Medicare & Medicaid Services to amend the MSC+ waiver. A copy of the January 17, 2022 letter to Tribal officials is provided at Attachment A. No comments were received.

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).

Minnesota has required its seniors over age 65 who are eligible for Medical Assistance whether dually eligible for Medicare and Medicaid or only eligible for Medicaid to enroll in managed care programs since the mid-1980's. Initially, seniors were included under the state's §1115 managed care waiver, the Prepaid Medical Assistance Program Plus (PMAP+), along with families and children. On June 1, 2005, Minnesota implemented a new §1915(b) waiver called Minnesota Senior Care/Minnesota Senior Care Plus (MSC/MSC+), and transferred all seniors who had been required to enroll under the §1115 waiver into the new §1915(b) waiver authority. The §1915(b) waiver authorized continued mandatory enrollment of seniors, including those dually eligible for both Medicaid and Medicare, in managed care in 83 of the State's 87 counties.

During the 2005 transition, existing managed care organization (MCO) contracts remained in place. No separate procurement process was conducted for the §1915(b) waiver, as it was not considered a new product, but rather a new authority for the same product. Because the senior population was already enrolled in the participating plans, members were not required to reenroll.

In 2007, the State procured MCO coverage for Minnesota Senior Care in Minnesota's remaining four counties (Beltrami, Clearwater, Hubbard and Lake of the Woods). Effective March 1, 2008, Minnesota Senior Care was then expanded to those remaining counties, making the program available in all 87 counties of the state.

The MSC+ program, which offers coordination of §1915(c) Elderly Waiver services under managed care, was phased in following the initial §1915(b) waiver implementation, beginning in 2005 with county-based purchasing entities. All non-metropolitan counties were added in 2008. Effective January 1, 2009, MSC+ was implemented in the seven county metropolitan area, making coordinated long term care benefits available in all 87 counties. From the inception of the waiver, MSC+ has offered coordination and delivery of home and community-based services and additional nursing facility services through managed care. This was not available under MSC. MSC+ includes 180 days of nursing facility benefit under managed care for seniors residing in the community, while 90 days of managed care nursing facility coverage was available for community enrollees in MSC. The Minnesota Senior Care Plus designation was previously used only to identify areas of the state in which coordinated home and community-based waiver services were available. Now that managed care organizations are able to provide these benefits in all counties, the State refers to this waiver as Minnesota Senior Care Plus (MSC+) and no longer uses Minnesota Senior Care/Minnesota Senior Care Plus (MSC/MSC+).

The MSC+ waiver operates in coordination with Minnesota's §1915(c) Elderly Waiver to enable the coordination and delivery of home and community-based services and additional nursing facility services through the MCOs. Seniors enrolled in MSC+ who are eligible for home and community-based services have those services coordinated through their MCO. Over the years, the §1915(c) waiver has been amended as needed to link community-based services to these revised managed care options for seniors.

Minnesota also continues to offer a voluntary option for seniors to enroll in Minnesota Senior Health Options (MSHO), an integrated Medicare/Medicaid product, which uses as its authority the state plan voluntary enrollment allowed under §1915(a). MSHO plans are Medicare Advantage Special Needs Plans (MA-SNPs). All MSC+ plans became SNPs in 2005, and also offer MSHO. MSHO also provides managed long term care services through the Elderly Waiver for seniors under §1915(c). Because of CMS policy allowing passive enrollment of dual eligibles into MA-SNPs offered by their Medicaid plan in 2006, most seniors covered by the §1915(b) waiver chose to enroll in MSHO instead.

Contracts for seniors are separate from the PMAP contract for families and children. The managed care contracts for seniors combine the MSHO and MSC+ products. This has enabled the State to implement contract requirements specific to the needs of seniors and to increase the focus on best practices for geriatric care.

As directed by the 2017 Minnesota legislature, the Minnesota Department of Human Services (DHS) applied under section 1915(i) of the Social Security Act to add housing

stabilization services to Minnesota's Medicaid plan. The state plan amendment was approved on August 1, 2019. These services are designed to help people with disabilities and seniors find and keep housing. Services became available to people who are eligible beginning July 2020.

DHS ~~has~~ applied under sections 1915(i) and 1915(k) of the Social Security Act to add Community First Services and Supports (CFSS) as a new Medical Assistance benefit. The new benefit will expand people's choices about how they receive their personal care services, including who can provide services, additional support for writing plans, more self-direction options and the ability to purchase goods to aid a person's independence. The new benefit permits the person to choose an agency provider or budget model of service delivery. Under the budget model, the person is the employer of their support workers. DHS plans to use the same eligibility criteria for CFSS as currently is used for personal care assistance (PCA) services. ~~t~~The new CFSS benefit will be available for seniors enrolled in managed care under the MSC+ and MSHO programs. All eligible seniors electing to transition to CFSS will receive an assessment under the new benefit.

The state's request to add CFSS to Minnesota's Medicaid plan under the §1915(i) and §1915(k) state plan options was submitted to CMS on March 18, 2022. Following receipt and response to CMS' request for additional information (RAI), DHS withdrew its RAI response. DHS submitted revised 1915(i) and 1915(k) requests to CMS on November 30, 2023, restarting the federal review period. The revised submission ~~addresses~~ addressed issues raised by CMS ~~and addressed~~ through technical assistance meetings that were held between October 2022 through November 2023. CMS approved the waiver amendment on February 27, 2024 with an effective date of June 1, 2024. The state is amending the effective date from June 1, 2024 to October 1, 2024.~~Upon federal approval of the waiver amendment, the new CFSS benefit will be available for seniors enrolled in managed care under the MSC+ and MSHO programs. All eligible seniors electing to transition to CFSS will receive an assessment under the new benefit.~~

Program Objectives

The objectives of the MSC+ waiver are to:

- Enable access to primary and preventive care visits, improve the management of chronic care conditions and promote best practices for appropriate quality care in delivery systems designed specifically to meet the needs of the seniors enrolled in Medicaid;

- Develop and maintain managed care service delivery systems that have incentives to provide and manage Medicaid services for seniors cost-effectively with maximum value; and.

- Improve coordination of Medicaid benefits, particularly long term care services, available to seniors in Minnesota by placing them under managed care delivery systems that offer additional oversight, care management, member services and other infrastructure supports not feasible under fee-for-service arrangements.

Mandatory Enrollment of Exempt Groups

Background. The Prepaid Medical Assistance Project Plus (PMAP+) section 1115 waiver has been in place for 30 years, initially as the federal authority for MinnesotaCare, which provided comprehensive health care coverage through Medicaid funding for people with income in excess of the standards in Medical Assistance. On January 1, 2015, the State converted MinnesotaCare to a Basic Health Plan (BHP) under the Affordable Care Act (ACA). As a BHP, MinnesotaCare receives federal funds based on a new payment formula related to advanced premium tax credits, and no longer receives Medicaid funds.

While federal waiver authority is no longer required for MinnesotaCare, the PMAP+ waiver remains necessary for continuing certain elements of Medical Assistance, including the authority to require certain populations to enroll in managed care. The PMAP+ waiver provided longstanding federal authority to require certain populations eligible for Medical Assistance to enroll in managed care that would have otherwise been exempt under the Social Security Act. In December of 2014, CMS notified DHS that it would need to transition its PMAP+ waiver authority, allowing the mandatory enrollment of certain groups in managed care, to a section 1915(b) waiver. On October 30, 2015 DHS submitted a request to amend the MSC+ waiver to continue federal authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care;
- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and
- Children under age 21 who are receiving foster care under Title IV-E.

The State updated the age limit to 21 from 19 to reflect changes in federal law allowing the age limit to be increased to age 21. Those changes apply to children who are in state-subsidized foster care, other out-of-home placement or Title IV-E foster care, and were approved by CMS effective January 1, 2016.

A. Statutory Authority

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

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

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

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

d. ___ **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._x_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c._x_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

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

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

The state agency chooses to use a competitive procurement requiring extensive disclosure of MCO capabilities for care management for this vulnerable elderly population. Requirements of the Request for Proposal process include descriptions of models of care, care transitions between institutional and community living, and processes for maintaining MSC+ enrollees in community living settings, as well as standard MCO capabilities such as good network adequacy and efficient administration.

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

1. **Assurances.**

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

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

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

_x_ 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)

3. **Rural Exception.**

_x_ 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)):

State Comment: The rural exception is used in the following counties: Beltrami, Big Stone, Brown, Clearwater, Douglas, Goodhue, Grant, Hubbard, Itasca, Kanabec, McLeod, Meeker, Pipestone, Pope, Renville, Sibley, Steele, Stevens, Traverse, and Waseca.

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.

_x_ **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.

Managed Care Contracts

Minnesota's managed care contracts are structured into three model contracts: Families and Children; Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) and Special Needs Basic Care (SNBC). The MSHO/MSC+ contract covers MA eligible persons age 65 and over who are dually eligible for Medicare and Medicaid as well as those who are eligible for Medicaid only. Most seniors in Medical Assistance are covered by the MSHO/MSC+ contract. If they do not voluntarily enroll in MSHO, they are required to enroll in MSC+.

Minnesota contracts with eight MCOs: HMO Minnesota d/b/a Blue Plus, HealthPartners, Itasca Medical Care, Medica, PrimeWest Health, South Country Health Alliance, UCare Minnesota, and United HealthCare of Illinois. The CFSS benefit is included in the 2024 contracts and becomes effective upon approval by CMS and following DHS' notification to the MCOs. Final contracts, rate setting methodologies and actuarial certifications were submitted in November 2023 to CMS for approval by the Division of Managed Care Operations.

A geographic representation of the location of MCO service areas and information about the number of plans under contract in each county for MSC+ can be found on the DHS web page at Health Plan Service Areas.

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

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

_x_ Mandatory enrollment (age 65 and older)
___ 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

_x_ **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.

_x_ Mandatory enrollment
___ Voluntary enrollment

_x__ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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).

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

State Comment: MSHO enrollees are excluded. Seniors who do not choose to enroll in MSHO, which is a voluntary program, will be required to enroll in MSC+. Upon disenrollment from MSHO, seniors will be subject to re-enrollment in MSC+.

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

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

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

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

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

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

___ **Other** (Please define):

F. Services

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

1. **Assurances.**

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

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

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

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

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

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

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

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

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

___ Family planning services are not included under the waiver.

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

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

State Comment: Pursuant to the contract and state law, the State requires the MCO to offer to contract with any FQHC or RHC in the MCO's Service Area. Medicaid services of FQHCs provided under the managed care contract are billed directly to the State. While the payment is outside the MCO contract, the enrollee gains access to services through the MCO. FQHCs are in-network for service access and enrollees remain eligible for all related benefits through the MCO.

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

5. **EPSDT Requirements.**

___The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

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

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

7. **Self-referrals.**

_x_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: family planning services; medical emergency or post-stabilization services; enrollee is out of the service area and requires urgent care; enrollee is out of the service area and requires ongoing care already prescribed in-network; services with rights to open access under Minnesota Statutes, Section 62Q.15, e.g. diagnosis of infertility,

testing and treatment of STDs, testing for AIDS or other HIV-related conditions.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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.

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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.

State Comment: The MCO must have effective mechanisms that assess the quality and appropriateness of care furnished to enrollees with special health care needs. All enrollees who are age 65 and over are considered to meet the State's criteria for special needs.

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.

State Comment: The MCO will perform a health risk assessment or screening of all enrollees and identify any ongoing special conditions of the enrollee that may require a course of treatment or regular care monitoring. For enrollees with special health care needs as determined through assessment, the MCO shall develop and implement a care treatment plan. The care treatment plan must be developed by a care manager in conjunction with the enrollee's primary care provider and with enrollee participation, and in consultation with any specialists caring for the enrollee. The care treatment plan must be approved by the MCO in a timely manner, if approval is required by the MCO.

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

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

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

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

e. _x_ **Direct access to specialists**. If treatment plan or regular care monitoring are 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.

State Comment: If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. The MCO's mechanism may be to use a standing referral or an approved number of visits as appropriate for the enrollee's condition and identified needs. The MCO must submit to the State a written update of the process used whenever the MCO makes material changes to the described method(s).

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

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

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

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

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

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

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

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

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

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

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

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.

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

_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

State Comment: The State's managed care quality strategy has been incorporated into the Comprehensive Quality Strategy. The Comprehensive Quality Strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid program. Minnesota's Comprehensive Quality Strategy can be accessed on the DHS website at Managed Care Reporting.

_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: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	IPRO	x	x	x (MN Dept. of Health)
PIHP				

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:

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.

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

___ 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.

State Comment: MCOs may make no more than two mailings per year to all recipients in a service area, using a mailing list provided by the State, in a format required by the State. MCOs may market directly through the publications and other marketing materials distributed by the local agency or the State, or through mass media advertising marketing materials (including the Internet) and may inform the recipients who reside in the service area of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, subject to State approval of materials. The MCO may distribute brochures and display posters at provider offices and clinics informing patients that the clinic or provider is part of the MCO's provider network, provided that all MCOs with which the provider contracts have an equal opportunity to be represented. The MCO may provide health education materials for enrollees in provider's offices.

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.

State Comment: The MCO contracts prohibits the MCO, its agent and marketing representatives from offering or granting any reward, favor or compensation as an inducement to a recipient or enrollee to enroll in the MCO. All marketing materials to potential enrollees are pre-approved by DHS.

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

3._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):

State Comment: The MCO shall determine and translate vital documents and provide them to households speaking a prevalent non-English

language whenever the MCO determines that five percent or 1,000 persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered speak a non-English language in the MCO's service area. For this purpose, "prevalent" means a non-English language spoken by a significant number or percentage of enrollees and potential enrollees. If a potential enrollee or enrollee speaks any non-English language, regardless of whether it meets the threshold, the MCO must provide that the potential enrollee or enrollee receive free of charge information in his or her primary language, by providing oral interpretation or through other means determined by the MCO. All MCO materials targeting recipients or enrollees must include the state's language block. The language block is a graphic block of text that directs readers, in multiple languages, to call the MCO to have the document translated. The language block includes: Amharic, Arabic, Burmese, Cambodian (Khmer), Cantonese (Chinese), French, Hmong, Karen, Korean, Lao, Oromo, Russian, Somali, Spanish, and Vietnamese.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

2. **Details.**

a. **Non-English Languages**

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

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

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

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

3._x_ Other (please explain):

State Comment: The MCO shall determine and translate vital documents and provide them to households speaking a prevalent non-English language whenever the MCO determines that five percent or 1,000 persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered speak a non-English language in the MCO's service area. For this purpose, "prevalent" means a non-English language spoken by a significant number or percentage of enrollees and potential enrollees. If a potential enrollee or enrollee speaks any non-English language, regardless of whether it meets the threshold, the MCO must provide that the potential enrollee or enrollee receive free of charge information in his or her primary language, by providing oral interpretation or through other means determined by the MCO. All MCO materials targeting recipients or enrollees must include the state's language block. The language block is a graphic block of text that directs readers, in multiple languages, to call the MCO to have the document translated. The language block includes: Amharic, Arabic, Burmese, Cambodian (Khmer), Cantonese (Chinese), French, Hmong, Karen, Korean, Lao, Oromo, Russian, Somali, Spanish, and Vietnamese.

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

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

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

iii._x_ Other (please explain):

State Comment: The contracts require MCOs to identify prevalent languages for translation. The 2021 contract provides: "The MCO shall

determine and translate vital documents and provide them to households speaking a prevalent non-English language whenever the MCO determines that five percent (5%) or one thousand (1,000) persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered in the MCO's service area speak a non-English language. For purposes of this section, "prevalent" means a significant number or percentage of enrollees and potential enrollees. If a potential enrollee or enrollee speaks any non-English language, regardless of whether it meets the threshold, the MCO must provide that the potential enrollee or enrollee receive, free of charge, information in his/her primary language, by providing oral interpretation or through other means determined by the MCO." The 2021 contract also provides that: "All material sent by the MCO to enrollees or recipients, that targets Recipients or Enrollees under this Contract, shall include the STATE's language block. The MCO may request a waiver from this requirement if special circumstances apply." The language block is a graphic block of text that informs readers, in multiple languages, how they can get help with understanding the information in a particular document at no cost to them. The language block includes 15 languages: Amharic, Arabic, Burmese, Cambodian (Khmer), Cantonese (Chinese), French, Hmong, Karen, Korean, Lao, Oromo, Russian, Somali, Spanish, and Vietnamese.

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

State Comment: The MCO is required by contract to provide oral translation to all potential enrollees or enrollees. MCOs meet this requirement by multi-lingual staff or by using a Language Line.

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

State Comment: Enrollment notices, informational materials and instructional materials are provided at a 7th grade reading level. The state or local agency provides information through enrollment materials or an on-site presentation, which help enrollees and potential enrollees understand the MCO program. The State identifies the prevalent non-English languages spoken throughout the state and make written information available in those languages. The State makes oral interpretation services available in any language and information about how to access interpretation services. Information is available in alternative formats and informs enrollees about how to access those formats. The State or local agency provides specific information at the time each Medicaid recipient becomes eligible to voluntarily enroll in a managed care plan or is first notified it is mandatory that they enroll in a managed care plan. The following information is provided within a timeframe that allows the potential enrollee a minimum of 30

days to review the information and choose a plan among the available MCOs in their county of residence. The information packet includes the basic features of managed care, populations excluded from enrollment and those that have the option to voluntarily enroll or be excluded. Information is also provided on MCO coordination of care responsibilities, benefits available under the State Plan that are not covered under the MCO contract, including how and where enrollees may obtain those benefits; and an explanation of cost-sharing and how to access services such as transportation and interpretive services. The packet also includes summary information specific to each MCO operating in the potential enrollee's service area and details benefits covered, cost sharing, a description of the service area and primary care clinics/providers contracted through the plan. The clinic and provider information includes location addresses, phone numbers, and any non-English language spoken by providers and whether specific providers are not accepting new patients.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_x_ State (via the county)
___ contractor (please specify) _____

___ 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) _x_ the State (through the county for pre-enrollment materials)
(ii) ___ State contractor (please specify):_____
(ii) _x_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider (for enrollment materials)

C. Enrollment and Disenrollment

1. **Assurances.**

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

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

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

b. **Administration of Enrollment Process**.

_x_ State staff conduct the enrollment process.

State Comment: State staff supervises county-administered enrollment.

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

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

Broker name: _____

Please list the functions that the contractor will perform:
___ choice counseling
___ enrollment
___ other (please describe):

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

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

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

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

_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.

State Comment: The State sends each enrollee a list of plans from which they may select. They are informed that, if they do not select one of these plan choices within 30 days, a plan will be automatically assigned to them.

i. _x_ Potential enrollees will have_30_days to choose a plan.
ii. _x_ 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 MMIS system assigns a default plan to each potential enrollee. The default health plan is determined by searching to find if any associated household members are enrolled in managed care and if that health plan is available for enrollment. If none of the household members are enrolled in managed care or the health

plan in question is not available for enrollment, the default plan is assigned on a rotating basis using all health plans available for assignment.

The State provides potential enrollees information about the health plans from which they may select. They are informed that if they do not select one of these plan choices within 30 working days, that a plan will be automatically assigned to them. The plan to which they will be auto assigned is indicated on the enrollment form sent to potential enrollees.

_x_ 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)
- ___ 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: _____

_x_ The State provides **guaranteed eligibility** of __6__ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

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

State Comment: Mandatory enrollees have the ability to request a state fair hearing.

_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:**

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

i._x_ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

_x_ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

_x_ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 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):

State Comment: Good cause includes agency error and other reasons as determined by a state human services judge through a fair hearing.

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

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

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

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

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

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

D. Enrollee rights.

1. **Assurances.**

_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.

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

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

E. Grievance System

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

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

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

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

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

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

_x_ 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.

_x_ 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.

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

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

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

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

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

b. **Timeframes**

_x_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is (30) days (between 20 and 90). An appeal may be filed within 90 days for good cause.

_x_ The State's timeframe within which an enrollee must file a **grievance** is (30) days. An appeal may be filed within 90 days for good cause.

c. **Special Needs**

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

State Comment: The Department has an ombudsmans office available to help any person who requires assistance with the grievance, appeal, or state fair hearing processes.

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

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

___ The grievance procedures 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 nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

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

The prohibited relationships are:

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

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

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

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

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

State Comment: As of the date of this amendment request, calendar year 2024 contracts are pending CMS approval.

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

Please refer to Appendix A for the Summary Chart of Monitoring Activities.

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

Comprehensive Quality Strategy

Minnesota's quality strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid managed care program. Minnesota has incorporated into its quality strategy measures and processes related to the programs affected by this waiver. The current version of the quality strategy can be accessed on the DHS website at Managed Care Reporting.

The quality strategy is developed in accordance with 42 C.F.R. § 438.340, which requires the state Medicaid agency to have a written strategy for assessing and improving the quality of health care services offered by MCOs.

The quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all managed care program enrollees. It incorporates elements of current DHS/MCO contract requirements, State licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. Part 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in managed health care programs. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal Medicaid and Medicare requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report by a contracted EQRO.

An evaluation of the effectiveness of Minnesota's 2020 Comprehensive Quality Strategy was conducted in January 2021. As a result of this review, the 2020 quality strategy was revised. The revisions were published in the state register for public comment and were presented to the Medicaid Services Advisory Committee for review and comment. The

revisions were reported to CMS in July 2021. This revision process resulted in the current 2021 Comprehensive Quality Strategy under which the state currently operates. A review of the effectiveness of Minnesota's 2021 Comprehensive Quality Strategy was conducted in June 2022. This review revealed that the quality strategy did not need to be updated at that time. A review of the effectiveness of the quality strategy was conducted in July 2023. As a result of this review, the quality strategy is expected to be available for public review in the spring of 2024. Any future modifications that are significant will be published in the Minnesota State Register to obtain public comment, presented to the Medicaid Services Advisory Committee and reported to CMS.

External Review Process

Each year the state Medicaid agency must conduct an external quality review of managed care services. The purpose of the external quality review is to produce the Annual Technical Report (ATR) that includes:

- Determination of compliance with federal and state requirements,
- Validation of performance measures, and performance improvement projects, and
- An assessment of the quality, access, and timeliness of health care services provided under managed care.

Where there is a finding that a requirement is not met, the managed care organization (MCO) is expected to take corrective action to come into compliance with the requirement.

The external quality review organization (EQRO) conducts an overall review of Minnesota's managed care system for Minnesota Health Care Programs enrollees. Part of the EQRO's charge is to identify areas of strength and weakness and to make recommendations for change. Where the ATR describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The EQRO follows up on the MCO's response to the areas identified in the past year's ATR. The ATR is shared with all MCOs under contract and other interested parties and is available upon request. The ATR is published on the DHS website at Managed Care Reporting.

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

_x_ NCQA
___ JCAHO
___ AAAHC

_x_ Other (please describe) (Medicare Certification CMS)

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

___ NCQA
___ JCAHO
___ AAAHC
_x_ Other (please describe) (Must meet applicable Minnesota Department of Health (MDH) requirements.)

c. __x__ Consumer Self-Report data

_x_ CAHPS (please identify which one(s) (DHS annually contracts with a certified CAHPS vendor to conduct 4.0H CAHPS survey of DHS' adult population)
___ State-developed survey
_ _ Disenrollment survey
___ Consumer/beneficiary focus groups

d. _x__ Data Analysis (non-claims)

_x_ Denials of referral requests (DHS will review)
_x_ Disenrollment requests by enrollee
  _x_ From plan (DHS/EQRO will review)
  ___ From PCP within plan
_x_ Grievances and appeals data (MDH, DHS and EQRO will review)
___ PCP termination rates and reasons
___ Other (please describe)

e. __x__ Enrollee Hotlines operated by State (DHS)

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

g. ____ Geographic mapping of provider network

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

i. __x__ Measurement of any disparities by racial or ethnic groups (DHS)

j. __x__ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP] (MDH, DHS)

k. __x__ Ombudsman (DHS)

l. __x__ On-site review (MDH, triennial per MCO)

m. _x__ Performance Improvement projects [**Required** for MCO/PIHP]

_x_ Clinical (MCOs will conduct in conjunction with Medicare QIP under CMS Duals Demonstration, DHS/EQRO will review, CMS will validate)

_x_ Non-clinical (MCOs will conduct in conjunction with Medicare QIP under CMS Duals Demonstration, DHS/EQRO will review, CMS will validate)

n. __x__ Performance measures [**Required** for MCO/PIHP]

_x_ Process (DHS will produce annual HEDIS measures)

_x_ Health status/outcomes (DHS will produce annual HEDIS measures)

_x_ Access/availability of care (DHS will produce annual HEDIS measures)

_x_ Use of services/utilization (DHS will produce annual HEDIS measures)

_x__ Health plan stability/financial/cost of care (MCOs report extensive financial information and are subject to a medical loss ratio requirement under 42 C.F.R. 438.4(b)(9))

___ Health plan/provider characteristics

___ Beneficiary characteristics

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

and after waiver

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

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

r. __x__ Test 24 hours/7 days a week PCP availability (MDH)
MDH conducts on-site audits which include a review of MCO policies and procedures to ensure PCP services are available and accessible 24 hours a day 7 days a week.

s. _____ Utilization review (e.g. ER, non-authorized specialist requests)
(These items are covered by Medicare)

t. __x__ Other: (please describe) (Ongoing DHS review of marketing materials, coverage information and other information produced by MCOs.)

Section C: Monitoring Results

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

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

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

_x_ This is a renewal request.

- ___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- _x_ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy:
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)

Strategy: a. Accreditation for Non-duplication

Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results: A summary of the results for this strategy can be found on page 50 and at Appendix C of the Department of Human Services Comprehensive Quality Strategy. The Comprehensive Quality Strategy can be accessed on the DHS website at Managed Care Reporting.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results:
Every MCO has met the applicable requirement.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level

Strategy: c. Consumer Self-Report data

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:
DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. DHS contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are reviewed by DHS and the Minnesota Department of Health. A report of the 2019 and 2020 surveys and their findings are published on the DHS web page at Managed Care Reporting.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: d. Data Analysis (non-claims)
Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results:
The MDH assesses MCO compliance with the requirements regarding the notice of action, which notifies consumers when services are denied, reduced or terminated. The assessment includes a review of language, format, content, and timing of the notices. The contract requires that each notice include both a description of the type of action being taken (i.e., denial of service, reduction of service, termination of service, or denial of payment) and the reason for the action. All of the notices for all MCOs meet these two requirements. The assessment also evaluates whether the reason for the action is consistent with the nature of the service and whether the notice will make sense to an enrollee receiving the letter. Most of the notices are consistent with the service and are understandable to a layperson. The results of these assessments are found in the MDH Quality Assurance Examination Audit, which is available on the MDH web page at https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html
Grievances and appeals are reported by the MCOs to the State's ombudsman each quarter. A detailed account of the EQRO findings and recommendations in this area can be found in the 2018 ATR.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: e. Enrollee Hotlines operated by State
Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:
The MHCP Member Help Desk provides information and referral services to persons who are on Minnesota's Health Care Programs: The MHCP Member Help Desk:

- Provides information about applications, eligibility, health care policy, benefits, and claims;
- Refers callers to appropriate health plan, county and state agencies for specialized information or services.

Callers disputing a health plan action are referred to the ombudsman for assistance. A tracking system is used to track caller concerns. The Minnesota Health Care Programs Member Help Desk numbers are (651)-431-2670 and 1-800-657-3739.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: f. Focused Studies

Strategy: g. Geographic mapping of provider network

Confirmation it was conducted as described:

___ Yes
_x__ No. Please explain:

Summary of results:
DHS relies by contract on the MDH for information on the adequacy of MCO provider networks. MCOs are required to submit networks to MDH upon initial certification and notify MDH of network changes pursuant to licensure. The MDH Quality Assurance Examination Audit includes a triennial review of MCO provider networks for adequacy and capacity. This information is reviewed by DHS.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

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)

Strategy: i. Measurement of any disparities by racial or ethnic groups

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

To ensure MCOs deliver services in a culturally competent manner, HEDIS performance measures are calculated each year to monitor utilization and demonstrate ongoing improvements. Some of these HEDIS performance measures can be adapted to assess race-based performance and identify if racial disparities exist. Encounter data submitted by the MCOs are used to calculate the performance measures and DHS enrollment demographics are used to identify enrollee race/ethnicity, age, and MHCP program.

Minnesota Health Care Disparities by Insurance Type Report - DHS contracts with Minnesota Community Measurement for the annual *Minnesota Health Care Disparities by Insurance Type Report*. The report compares quality measures' rates between the managed care Medicaid population and other payers. It also shows racial disparities among the Medicaid managed care population. The report for 2019 is published at https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/2019%20Disparities%20by%20Insurance%20Type.pdf

DHS Disparities Dashboard – The disparities dashboard has been created using data from the Minnesota Community Measurement's Health Care Disparities report. It serves as an internal tool to search individual clinic-level results

Minnesota Community Measurement research – In addition to the Health Care Disparities Report, Minnesota Community Measurement began providing DHS with additional social determinants of health data to further understand drivers of healthcare disparities. This information will not be published in the public report, but will be used internally.

IHP equity interventions – Before IHPs propose their equity interventions, the IHP team produces reports on social determinate of health among a given IHP population. The results are not published, they are used by DHS and a given IHP to facilitate discussions about equity interventions.

Quality Dashboard – Recently created to show quality measures' rates stratified by race. The dashboard is not published. For now it will be used for internal purposes.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results: The MDH reviews MCO compliance with Minnesota managed care regulations in the area of availability and accessibility. The results of this review are found in the MDH Quality Assurance Examination Audit, which is available on the MDH web page at https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html The results are summarized in the 2018 ATR.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: k. Ombudsman

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

The Ombudsman for Managed Health Care Programs works with people enrolled in MCOs for Medical Assistance and MinnesotaCare to resolve access, service and billing issues and to ensure that medically appropriate services are provided. The ombudsman:

- Resolves disputes and complaints through mediation, negotiation, education or referral to appropriate county, state or federal agencies or legal services;
- Provides assistance with the complaint and appeal process available through the health plan and the state;
- Provides information and education about consumers' rights, laws and regulations and the financing of health care services through written materials, individual consultation or public speaking; and
- Advocates for change to better meet consumer needs.

The ombudsman tracks MCO grievances and appeals as well as state fair hearings related to managed care for seniors. Data is used by contract managers to identify systemic issues. This information is also reviewed as part of the MDH audit and summarized in the EQRO/Annual Technical Report.

The ombudsman website is: Ombudsman for Public Managed Health Care Programs.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: l. On-site review

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

On-site compliance audits for each MCO are conducted by the MDH on a rotational, triennial schedule to assess compliance with managed care regulations and to collect information needed by DHS to meet external quality review requirements. The MDH QA Examination Audit results and DHS supplemental findings are summarized in the Annual Technical Reports. The results of MDH Quality Assurance Examination Audits are also published on the MDH public website at: https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Strategy: m. Performance Improvement projects [**Required** for MCO/PIHP]

_x_ Clinical MCOs will conduct, DHS/EQRO will review
_x_ Non-clinical MCOs will conduct, DHS/EQRO will review

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

All MCOs are required to submit proposals for performance improvement projects (PIPs) annually for DHS review and approval. MCOs are instructed to follow a ten-step protocol outlined by CMS in the document entitled "Conducting Performance Improvement Projects." A summary of PIP proposals and results are reported in the 2018 ATR. MCOs participating in MSC+ began participating in a joint Medicare-Medicaid QIP as part of the CMS Duals Demonstration in 2016.

Problems identified:

Corrective action (plan/provider level)

Strategy: n. Performance measures [**Required** for MCO/PIHP]

`

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:

DHS produces HEDIS measures that are audited by an independent, certified HEDIS auditor. Results are reported in the 2018 ATR.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

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

Strategy: q. Provider Self-report data

___ Survey of providers
___ Focus groups

Strategy: r. Test 24 hours/7 days a week PCP availability MDH

Confirmation it was conducted as described:

_x_ Yes
___ No. Please explain:

Summary of results:
The MDH reviews MCO compliance with Minnesota managed care regulations in the area of availability and accessibility. The results of this review are found in the MDH Quality Assurance Examination Audit, which is available on the MDH web page at https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html and are summarized in the 2018 ATR.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

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

Strategy: t. Other: DHS review of marketing materials, coverage information and other information produced by plans.

Confirmation it was conducted as described:
_x_ Yes
___ No. Please explain:

Summary of results:
All marketing materials to potential enrollees are pre-approved by DHS.

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to the State's PMPM for each MEG times actual enrollee months in the ~~waiver~~ cost projections for each MEG.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual

Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid ~~Financial~~ Officer making these assurances: Patrick Hultman

c. Telephone Number: (651) 431-4311

d. E-mail: patrick.hultman@state.mn.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 4 years) upon the second renewal and thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

Not Applicable

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.

For the Institutional and Community Elderly MEGs, R1 and R2 data reflect the population enrolled in MSC+ only.

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 the Institutional and Community Elderly MEGs, R2 includes two quarters of actual payments per CMS 64 and eight months of actual enrollment (reflecting available data at the time projections were made).

For the MEG including Foster Care Children and American Indians, R2 includes two quarters of actual payment or MMIS, the State's claims payment system, and six months of actual enrollment.

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

For the Institutional and Community Elderly MEGs, member months are increased from R2 to P1 through P5 based on enrollment trends of the elderly managed care population of MSC+.

Annual rates of change by MEG and time period are shown in the following table, using data by standard July to June SFY:

Time Period	Institutional MEG	Community and Community-EW MEGs	Total Elderly Population
SFY 2020 - SFY 2021	0.43%	12.15%	10.28%
SFY 2021 - SFY 2022	3.16%	11.08%	9.93%
SFY 2022 - SFY 2023	3.16%	7.29%	6.73%
SFY 2023 - SFY 2024	3.16%	7.33%	6.78%
SFY 2024 - SFY 2025	3.16%	7.36%	6.83%
SFY 2025 - SFY 2026	3.16%	7.40%	6.88%

For the MEG including Foster Care Children and American Indians, member months are increased from R2 to P1 through P5 based on enrollment trends of the Foster Care Children and American Indian managed care populations of MSC+.

d. __ [Required] Explain any other variance in eligible member months from BY/R1 to P2: Any variance is explained in the previous answer

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

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

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

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: _____

All capitated services for waiver enrollees are included in the calculation of cost-effectiveness. All services provided on a fee-for-service basis are excluded from the cost-effectiveness calculation. FFS payments to FQHCs made during managed care enrollment periods are excluded from the cost-effectiveness calculations (per CMS instructions in the 1915(b) preprint). On August 1, 2019 CMS approved the state's request to add housing stabilization services to Minnesota's Medicaid plan under the 1915(i) state plan option. The addition of this benefit has not resulted in any adjustment to the MSC+ cost-effectiveness projections at this time.

On March 18, 2022, DHS submitted a request to add CFSS to Minnesota's Medicaid plan under the 1915(i) and 1915(k) state plan options. Following receipt and response to CMS' request for additional information (RAI), DHS withdrew its RAI response. DHS submitted revised 1915(i) and 1915(k) requests to CMS on November 30, 2023, restarting the federal review period. The revised submission ~~addresses~~ addressed issues raised by CMS ~~and addressed~~ through technical assistance meetings that were held between October 2022 through November 2023. CMS approved the waiver amendment on February 27, 2024 with an effective date of June 1, 2024. The state is amending the effective date from June 1, 2024 to October 1, 2024. Upon approval of the waiver amendment and DHS' notification to the MCOs, the CFSS benefit will be available for seniors enrolled in managed care under the MSC+ and MSHO programs. The addition of the CFSS benefit has resulted in an adjustment to the MSC+ cost-effectiveness projections as described in Section D.I.I.b.

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

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

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ 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 has followed the administrative cost allocation methodology set forth in the base year cost-effectiveness analysis to report administrative cost under this waiver. The allocation methodology takes into account:

- The number of waiver enrollees as a percentage of total Medicaid enrollees
- The waiver costs of the waiver population as a percentage of the total Medicaid costs of the waiver population

H. Appendix D3 – Actual Waiver Cost

For the Institutional and Community MEGs, Appendix D3 is completed using the monthly data that underlies the CMS-64 expenditure reports. R1 includes 12 months of CMS-64 cost data. R2 includes six months of CMS-64 cost data.

For the MEG including Foster Care Children and American Indians, Appendix D3 is completed using the monthly data that underlies the CMS-64 expenditure reports. R1 includes 12 months of CMS-64 cost data and R2 includes six months of CMS-64 cost data.

In addition to the monthly capitation payments, the following payments are included in Appendix D3 for all MEGs:

- MCO Withhold Payments

  State law requires the Department of Human Services to withhold a portion of managed care plan payments pending completion of performance targets.

  For capitation payments made in CY 2014 and later, the State withholds 8.0% from the basic care capitation rates. The withheld payments are paid in July following the end of the CY during which payments are withheld. The withheld payments are included in CMS-64 in the quarter when they are paid.

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.

Not Applicable

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

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

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

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

b._ x_ 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:

A small number of seniors who meet the criteria for Serious and Persistent Mental Illness are allowed to volunteer to enroll. Since the historical cost base utilized for MSC+ included the costs for these populations and there have been no changes in the enrollment process or proportion of people choosing to enroll since that period, no additional adjustments were necessary.

c._X_ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description

is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

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

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

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

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

i. Document the criteria for awarding the incentive payments.

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

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

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

Not Applicable

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

Not Applicable – see Section J

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

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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

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

b. _x_ **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._x_ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

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

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

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

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

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

D.____Other (please describe):

iv._x _Changes in legislation (please describe)
For each change, please report the following:

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

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

PMPM Effect of Program Adjustment

	Total PMPM State Plan Service Cost Projection Prior to Adjustment	**Total PMPM State Plan Service Cost Projection Adjusted for CFSS**	**PMPM size of Adjustment**
P4	$1,081.24	$~~1,088.52~~1,085.35	$~~7.28~~4.11

P5	$1,134.94	$~~1,150.47~~1,147.65	$~~15.53~~12.71

An updated cost effectiveness spreadsheet is provided at Attachment B. Please see adjustments made to tab D5 Waiver Cost Projection, Column L Program Adjustment, Prospective Years 4 and 5.

Please see spreadsheet at Attachment C for calculation of CFSS impact on managed care rates.

C. ____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ____Other (please describe):

v.___Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.
1.___ No adjustment was necessary and no change is anticipated.
2.___ An administrative adjustment was made.
i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe):
ii.___ FFS cost increases were accounted for.

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

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

C.____Other (please describe):

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

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

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

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

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

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e.,*

trending from present into the future), the State must use the State's trend for State Plan Services.

i. State Plan Service trend

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

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

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

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

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

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

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine GME adjustment based on a pending SPA.

3.___ Determine GME adjustment based on currently approved GME SPA.

4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9

Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

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

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

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

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

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

Method:

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

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

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

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

Basis and Method:

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

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

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

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

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

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

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs: The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to

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

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

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

  1.___ No adjustment was made.

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

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

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

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

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner.

CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

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

1._X_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: 6.17% for the Institutional and Community Elderly MEGs and 0.5% for the MEG including Foster Care Children and American Indians. Please document how that trend was calculated:

For the Institutional and Community Elderly MEGs, the 6.17% trend is calculated from the actual overall waiver PMPM for FY 2020 ($1735.05) compared to the actual overall waiver PMPM for FY 2016 ($1365.53): (1735.05 / 1365.53) ^ (1/4) = 1.0617. CMS-64 payments and actual waiver member months were used to calculate the PMPM for each FY.

For the MEG including Foster Care Children and American Indians, the 0.5% trend is calculated from the actual overall waiver PMPM for FY 2020 ($338.63) compared to the actual overall waiver PMPM for FY 2016 ($332.26): (338.63 / 332.26) ^(1/4) = 1.005. CMS-64 payments and actual waiver member months were used to calculate the PMPM for each FY.

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

i. _X_ State historical cost increases. Please indicate the years on which the rates are based: base years SFY 2016 to SFY 2020 actual waiver PMPMs for the Institutional and Community MEGs and the MEG including Foster Care Children and American Indians. In addition, please indicate the mathematical method used (multiple

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

See above. The 6.17% overall trend is applied to all three Institutional and Community MEGS. The 0.5% trend is applied to the MEG including Foster Care Children and American Indians.

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 PMPM.

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

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

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

Utilization adjustments are included in the trend development described in Section 2 above.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA*

per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

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

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

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

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

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

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

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

v.__ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D.____Other (please describe):

v.___ Other (please describe):

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

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

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

D.___Other (please describe):

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

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

2._X_ An administrative adjustment was made.

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

ii._X_ Cost increases were accounted for.

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

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

C._X_ State Historical State Administrative Inflation. The actual trend rate used is: ___2.0%___. Please document how that trend was calculated:

An annual trend rate of 2.0% was chosen to trend from R1 to P1 and P2 based on the State's expectation of future administrative cost trends.

D.____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.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.

Not Applicable – the waiver does not include 1915(b)(3) services.

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.

Not applicable – the waiver does not include incentive payments that are not in the capitation rates.

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

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

3. Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost

effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Basis and Method:

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

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

3.___ Other (please describe):

1.___ No adjustment was made.

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

K. Appendix D5 – Waiver Cost Projection

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

See Section D.I.J above.

L. Appendix D6 – RO Targets

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

See Section D.I.E above.

M. Appendix D7 - Summary

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

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**:

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**:

   Unit cost changes are a component of the trend adjustments described in Section D.I.J. The State chose to compute its expected trends on a PMPM basis rather than separate the trend into utilization and unit cost components. Please refer to Section D.I.J for an explanation of the trend development.

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**:

   Utilization cost changes are a component of the trend adjustments described in Section D.I.J. The State chose to compute its expected trends on a PMPM basis rather than separate the trend into utilization and unit cost components. Please refer to Section D.I.J for an explanation of the trend development.

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Summary Chart of Monitoring Activities
Appendix A

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

Appendix B

March 1, 2021

Dear Tribal Leaders

This is to inform you that the Minnesota Department of Human Services (DHS) must submit a request to renew the Minnesota Senior Care Plus (MSC+) waiver to CMS by March 31, 2021. Current authority for the MSC+ waiver ends on June 30, 2021. DHS proposes to extend the existing waiver for an additional five years. No significant changes to the waiver are proposed.

The MSC+ waiver allows Minnesota to require seniors to enroll in managed care to receive Medicaid services. This includes seniors who are eligible for Medicare and Medicaid or only eligible for Medicaid and who have not opted to enroll in Minnesota Senior Health Options (MSHO). The waiver operates in combination with Minnesota's Elderly Waiver program to enable the integration of community-based long term care services into the managed care service delivery system. The waiver also provides federal authority to require certain other populations eligible for Medical Assistance to enroll in managed care, including American Indians and children who are in foster care or other out-of-home placement. The waiver does not alter the state policy that provides that American Indians who reside on a reservation are not required to enroll in a managed care program. American Indians who do not live on a reservation are required to enroll in managed care; however, if they receive health care services at a tribal or IHS facility, DHS will reimburse that facility even if it is not in the managed care organization's network.

A copy of the MSC+ renewal application has been included with this letter for your review. We would appreciate any comment or advice by March 31, 2021. Please direct any comments or questions you may have regarding the MSC+ waiver renewal to Jan Kooistra at jan.kooistra@state.mn.us.

Thank you in advance for your consideration.