

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

December 14, 2010

This document is being utilized for a renewal of Alabama's 1915(b) waiver which governs the state's Patient 1st Program and the Maternity Care Program.

Submitted:

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Contact:

Nancy Headley, R.N.

Director

Medical Services Division

Alabama Medicaid Agency

501 Dexter Avenue, P. O. Box 5624

Montgomery, Alabama 36103-5624

Office: (334) 242-5684

FAX: (334) 353-4818

nancy.headley@medicaid.alabama.gov.

Table of Contents

Facesheet	3
Section A: Program Description	5
Part I: Program Overview	5
A. Statutory Authority	17
B. Delivery Systems	19
C. Choice of MCOs, PIHPs, PAHPs, and PCCMs	21
D. Geographic Areas Served by the Waiver	22
E. Populations Included in Waiver	24
F. Services	27
Part II: Access	42
A. Timely Access Standards	42
B. Capacity Standards	45
C. Coordination and Continuity of Care Standards	50
Part III: Quality	54
Part IV: Program Operations	58
A. Marketing	58
B. Information to Potential Enrollees and Enrollees	60
C. Enrollment and Disenrollment	63
D. Enrollee Rights	71
E. Grievance System	72
F. Program Integrity	75
Section B: Monitoring Plan	77
Part I: Summary Chart	79
Part II: Monitoring Strategies	83
Section C: Monitoring Results	88
Section D: Cost Effectiveness	95
Part I: State Completion Section	95
Part I: Appendices D1-7	
Included in Attachment Seven	
Attachments:	
One – Patient 1 st Contract	
Two – REOMBs	
Three – PMPs by PMP County	
Four – PMPs by Recipient County	
Five – Sample Profiler	
Six – Sample RMEDE In-Home Monitoring Report	
Seven – Cost Effectiveness Worksheets	

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 Alabama requests a waiver/renewal 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 Patient 1st/Maternity Care Program. (Please list each program name if the waiver authorizes more than one program.)

Type of request. This is an:

N/A initial request for new waiver. All sections are filled.

N/A 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.

 X renewal request

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

 X The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is X replaced in full

 carried over from previous waiver period. The State:
 assures there are no changes in the Program Description from the previous waiver period.
 assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is X replaced in full

 carried over from previous waiver period. The State:
 assures there are no changes in the Monitoring Plan from the previous waiver period.
 assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective 6/1/2011 and ending 5/31/2013. (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 Nancy Headley, R.N. and can be reached by telephone at (334)242-5684, fax at (334) 353-4818, or e-mail at nancy.headley@medicaid.alabama.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

This one waiver governs two managed care programs: Patient 1st and the Maternity Care Program. Patient 1st is a traditional PCCM model. The State contracts directly with physicians throughout the State who have agreed to serve as PMPs (primary medical providers). During this waiver period, the State will implement enhancements to its PCCM program, by establishing regional networks within local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients.

The new program will now have two components:

- A traditional PCCM program where beneficiaries must select (or be assigned to) a primary medical provider (PMP). The PMP must agree to the terms of the State contract and is responsible for providing directly or through referral, necessary medical care. PMPs are paid a case management fee depending on how they choose to meet contract requirements. The underlying State plan medical services provided by the PMPs are paid on a fee-for-service basis. The State has developed and implemented a shared savings arrangement with PMPs that rewards PMPs for performance on three key metrics: Generic prescribing; reduction in non-emergent ED visits; and number of office visits.
- A care management enhancement which is operationalized through regional networks (Care Network). These networks will be non-profit entities with governing boards comprised of over 50% practicing physicians in the community. Each network in operation during this waiver period in three pilot areas of the State, will have a contract directly with the State to provide enhanced care management services and provide support to the PMPs participating in the traditional program. PMPs will not be required to have a contractual relationship with the Care Network in their area; however, they can receive higher PMPM fees if they do, as well as get the benefit of the increased care management support the Care Network can provide.

Individuals enrolled in the Patient First program also receive in-home monitoring services and case management (both provided as (b)(3) services). More detail is available under the description of (b)(3) services.

The Maternity Care Program changed from a classification of a PIHP to a PAHP due to the hospital component being removed effective with the amendment approved for 1/1/2010. Through the Maternity Care Program, the State contracts with 14 administrative entities throughout the State. These entities are known as Primary Contractors. Primary Contractors, in turn, have the responsibility for establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care. Upon delivery, the Primary Contractor is paid a global fee and is responsible for paying all subcontractors involved in the woman's care with the exception of the hospital component. Hospital delivery and postpartum days will be paid fee for service effective January 1, 2010. Services provided by a physician associated with a

teaching facility as defined in the State Plan will also be excluded from the global payment.

Individuals enrolled in the Maternity Care program may receive care coordination (provided as a (b)(3) service). More detail is available under the description of (b)(3) services.

The State also provides a Hemophilia management program to certain individuals (as a (b)(3) service). More detail is provided under the description of (b)(3) services.

Tribal consultation

Alabama has one federally recognized tribe, the Poarch Band of Creek Indians with members primarily located in one county. It is estimated that there are approximately 220 federally recognized tribal members that are Medicaid eligible. In the past, the Agency has worked closely with tribal leaders to ensure that Patient 1st and the Maternity Care Program did not interfere with the ability for tribal members to receive care. In Alabama, the medical center run by the tribe is classified as an FQHC and is an enrolled Medicaid provider.

The clinic provides limited services; therefore, many tribal members seek care from community providers. The clinic is enrolled as a Patient 1st provider to serve their tribal members. If tribal members are assigned to other Patient 1st providers however, they can elect to receive services from the tribal clinic. To facilitate billing of these services, the clinic has been provided a blanket referral from the State.

The Agency mailed a letter to the tribal chief to inform the tribe of the intent to renew this waiver and seek any input from the tribe.

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).

Patient 1st

These programs are rather unique in that both have been around for a number of years, yet both have had a history of operational dates and regulatory authority. While under the same waiver umbrella, these programs operate autonomously.

The Patient 1st Program actually began January 1, 1997 and was operational until February 29, 2004. The State chose not to pursue renewal of the program at that time due to administrative and budgetary constraints. By February 2005, the Patient 1st Program was reimplemented statewide.

The overarching goal of Patient 1st is to provide our Medicaid recipients a medical home. The physician patient relationship is paramount. Through this relationship, patient education and compliance has been successfully addressed. With the established medical

home, the Agency feels that it can effect change in unnecessary pharmacy utilization and inappropriate emergency room utilization.

Within the Patient 1st Program, patients are assigned to a primary medical provider (PMP). The PMP is responsible for providing directly, or through referral, necessary medical care. PMPs are paid a varying case management fee depending on how they choose to meet contract requirements.

Alabama's physician report card, the Profiler, helps the PMP understand the medical and cost utilization of his panel as compared to his peers. The Profiler illustrates the performance measures that will enable the PMP to share in program savings

Through Patient 1st, providers have access to two patient management tools: in-home monitoring and an electronic health record, QTool, which was developed via a Medicaid transformation grant. The in-home monitoring program allows a patient to record certain vital signs and/or test results at home and transmit the data to a central repository that allows a PMP to monitor a patient's condition on an on-going basis.

Patient 1st Program Highlights

The implementation of a staggered case management fee to the PMP has been successful in assisting the Agency in promoting areas of program management that will have the greatest impact. For the waiver period 4/1/09 – 3/31/11, the case management fee components were:

24/7 Voice to Voice Coverage: The PMP must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week.

Radiology Management: The Agency implemented a prior authorization process for Radiology services (e.g. CT scans, MRI, PET etc). The PMP is required to participate in this process.

InfoSolutions Electronic Health Record (TFQ): PMP was paid an additional case management component for utilization of InfoSolutions and use the QTool. The QTool was a component of the Together for Quality initiative and Alabama's version of an electronic health record. This fee was to incentivize the providers to use electronic technology. They had to meet the following utilization benchmarks 25% of recipient visits the first 3 months and 50% of recipient visits thereafter once the capability was available within their county.

Administrative fee: An administrative fee is built into the case management fee to offset the cost/time spent on completing program documentation for recipient services (ex. Radiology prior approval requests, patient referrals, In-Home monitoring patient enrollment forms, etc.)

Each PMP could earn as much as \$2.60 PMPM as follows:

- 24/7 Voice to Voice Coverage – \$1.00 PMPM
- Radiology Management -\$.50 PMPM
- InfoSolutions Electronic Health Record (TFQ)- \$1.00 PMPM
- Administrative fee-\$.50 PMPM

However, the average case management fee is \$1.68.

As part of the continual review process, Agency staff identified the need to overhaul the case management fee components. The data gathered showed the percentage of PMP participation in each of the components was less than expected. As with the development of the performance measures, the impact to the Agency and the importance to waiver goals were examined.

To accomplish this, Patient 1st Advisory Council meetings were held via conference call and face-to-face so all stakeholders would have the opportunity to provide input. Council member representation included private practice physicians, group practice physicians, Alabama Primary Health Care Association, Rural Health Care, MASA and the Alabama Academy of Pediatrics.

Consequently for the renewal period, changes in the fee structure for the traditional PCCM program will be implemented. For PMPs in areas of the State that **are not included in** the enhanced care management program through regional networks, the fees shall be as follows:

24/7 voice-to-voice requirement	\$1.00
Average Patient Acuity Level*	\$1.00 or \$1.60
Max total PMPM	\$2.60

A new component of the fee schedule is a variable fee based on the acuity of each patient; low risk patients will generate a \$1/PMPM fee, while high-risk patients will generate a \$1.60/PMPM fee.

The Alabama Medicaid Decision Support Tool in the MMIS which currently generates the PMP Quarterly Profiler Report (report card) will be utilized to identify the illness burden of Patient 1st recipients on a provider’s panel compared with the illness burden of recipients assigned to the provider peer group. The profiler utilizes Adjusted Clinical Grouping (ACG) weights designed by John Hopkins University. The average acuity level of each physician/practices’ panel of patients will be determined and fall into either a ‘low’ or ‘high’ category.

For PMPs in areas of the State that **are included** in the enhanced care management program (Care Network), the monthly PMPM fees shall be as follows:

A. PMP participates with the Care Network

24/7 voice-to-voice requirement	\$1.00
Network participation Fee	\$0.50
Average Patient Acuity*	\$1.00 or \$1.60
Max total PMPM	\$3.10

B. PMP DOES NOT participate with Care Network

24/7 voice-to-voice requirement	\$1.00
Max total PMPM	\$1.00

The Care Networks will also be paid a PMPM fee. This fee is based on the number of enrollees participating in the network, The number of enrollees is determined monthly based upon the Patient 1st PMP panel for each PMP agreeing to participate in the Network. The established PMPM is \$5.00 for Aged Blind and Disabled clients and \$3.00 PMPM for all other Patient 1st clients.

Maternity Care Program

The Maternity Care Program began in 1988 under the original 1915(b) waiver authority. The waiver was developed in an effort to address Alabama’s high infant mortality rate, the high drop-in delivery rate and the lack of delivering physician participation. The basic program concept integrated a change from a PIHP to a PAHP effective January 1, 2010. The State contracts with one administrative entity for each district through a competitive bid process. This entity is known as the Primary Contractor. The Primary Contractor, in turn, has the responsibility for establishing a comprehensive network of subcontractors that can provide prenatal, delivery and postpartum care. Medicaid pays for approximate half or 30,000 of all deliveries in the State of Alabama. The state’s 67 counties are divided into 14 districts for the operation of the Maternity Care program.

Maternity Care Program Highlights

In designing the program for the new contract period a series of town hall meetings were conducted by the Agency at five locations throughout the state. In addition a Maternity Care Advisory Review Committee was formed to review the comments from the town hall meetings and assist the Agency in program design combining the basic premise of a coordinated system of care with any changes optimizing birth outcomes.

Program changes include the requirement that Primary Contractor staff be trained as application assisters to assist women in obtaining eligibility quicker; a screening for mental health needs; an emphasis on smoking cessation; access to Medicaid covered contraceptives through local pharmacies; utilization of the Agency website to offer education and resources to the care coordinators, and better coordination between the Maternity Care Program care coordinator and the Plan First care coordinator. In addition, the Agency is proposing Performance Incentive Payments to the Primary Contractors. These payments are intended to promote improved safety and quality outcomes by supporting the use of best practice guidelines. Specific measures have been developed that will be monitored per the Agency web based data collection system and medical record documentation.

Performance Incentive Measures
1. 5% of the total number of enrolled mothers quit smoking and continue to abstain from smoking until the post partum visit
2. Establish and/or maintain one Centering pregnancy site for an entire year

3. 50% of all diabetic women in district have at least one session with a registered dietician.
4. 85% of all delivering women in district have a family planning visit by the 60 th postpartum day .
5. 11 prenatal visits were completed per total number of paid deliveries.
6. 25% of total deliveries per district are identified as breast feeding.
7. 75% of all delivering women complete first visit at <14 weeks.

We will continue to explore and implement measures that will foster improvement in our efforts in providing an environment for optimal birth outcomes.

Our 2009 performance improvement projects directed us in the path of increased recipient education. Our efforts were focused on the Five A's of counseling for recipient smoking cessation. An analysis of data from the districts was performed by the University of Alabama Analytics Department and forwarded to the districts. The addition of the requirement for application assistors with the contract effective 1/1/2010 will be monitored for improvement of early entry into care. The Agency has established a workgroup for the development of the next Performance Improvement Project. The workgroup is comprised of representatives from the Agency Maternity Care Program staff, district Primary Contractor Directors and Primary Contractor Quality Assurance staff. Emphasis will remain on optimal birth outcomes, quality care, and recipient satisfaction.

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): To facilitate review of the program, an X is used if the authority applies to both programs. Otherwise the program distinction is made with P1st indicating Patient 1st and MCP indicating Maternity Care Program.

- a. P1st **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. N/A **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. X **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

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

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

N/A MCO

N/A PIHP –

MCP PAHP (*Maternity Care Program*)

P1st 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.)

N/A 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. N/A **Section 1902(a)(1)** - Statewide--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. MCP **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. N/A **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.

NOTE: The Maternity Care Program will be known as “MCP” and Patient 1st will be known as “P1st”. If the requirement/description governs both programs, the “X” is indicated.

B. Delivery Systems

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

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

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

The PIHP is paid on a risk basis.

The PIHP is paid on a non-risk basis.

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

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

- d. P1st **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. N/A **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. N/A **Other:** (Please provide a brief narrative description of the model.)

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

- MCP **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
P1st **Open** cooperative procurement process (in which any qualifying contractor may participate)
 Sole source procurement
 Other (please describe)

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

1. **Assurances.**

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.

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

Within each district of the Maternity Care Program, the State has one Primary Contractor through bid procurement to serve as the administrative entity, through a competitive bid process. The Primary Contractor; however, must contract with any willing provider within the district. The patient has complete choice of those providers within her district. Throughout the life of the program, it has always operated with only one administrative entity.

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

 Two or more MCOs

P1st 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.

MCP Other: (please describe) There is only one administrative entity for each maternity care district but the eligible has a choice of providers within the network.

3. **Rural Exception.**

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

4. **1915(b)(4) Selective Contracting**

N/A Beneficiaries will be limited to a single provider in their service area (please define service area).

N/A 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.

E. Populations Included in Waiver

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

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

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

X Mandatory enrollment
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

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
___ Voluntary enrollment

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

X Mandatory enrollment
___ Voluntary enrollment

P1st **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

NO **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

N/A **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))

P1st 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. If it is a HMO with a limited network.

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

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

N/A 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.

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

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

P1st **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

X **Other** (Please define):

There may be individuals, decided on a case-by-case basis, which would not benefit from either program. For Patient 1st, these individuals typically have complex medical conditions that are being coordinated by a specialty care provider. Between January and September 2010 there were 337 exemptions approved for medical reasons. Additionally, there may be foster children or eligibles living in an institutional setting that might be exempted. Before any individual is exempted from participation, the provider serving that individual is given the opportunity to participate as a PMP for that patient.

Under the Maternity Care Program, a woman may be exempted if she has received Medicaid eligibility late in her pregnancy and her chosen doctor does not participate. These individuals receive their services through Medicaid fee-for-service arrangement. Further details on program exemptions can be found at A.IV.C.c.

For the period January 2010 through September 2010 there were a total of 74 women exempted from the Maternity Care Program for the following reasons:

- 3rd Trimester - 68
- Medical -
- TPL – 5
- Denied-1
- Other - 0

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)

N/A 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.

The contract for the Maternity Care Program changed from a PIHP to a PAHP with an amendment effective January 1, 2010. The Invitation To Bid, Maternity Care Program Operational Manual and the CMS Checklist were approved and have had no changes since this amendment was submitted and approved.

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

X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver. Pharmacy benefits are not included in either program.

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.

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

Note: While neither program restricts access to emergency services, the recipient information does educate patients how to access these services. Recipient education materials were approved with the original waiver and have not changed.

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:

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

N/A 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

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

N/A Other (please explain):

X Family planning services are not included under the waiver.

Note: While neither program restricts access to family planning services, the recipient information does educate patients on how to access these services. Recipient education materials were approved with the original waiver and have not changed.

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:

N/A 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:

Patient 1st

Any provider willing to meet requirements is allowed to participate and FQHCs are historical providers of care in Alabama. Patients have the ability to choose an enrolled FQHC as their PMP. There are currently 92 FQHC clinics enrolled as PMPs.

Maternity Care Program

In the MCP, FQHCs can either serve as a Primary Contractor or as a subcontractor. There are currently no FQHC as a Primary Contractor, but there are 7 FQHCs serving as subcontractors with multiple clinic sites.

N/A 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.

P1st 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.

X 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.

Patient 1st Program

Patient 1st continually seeks innovative programs and tools to assist physicians. During the renewal period, the State will offer case management services.

ADPH Case Management

The State has seen the effects of having case management services available to our clients. We use the case management models in all of our waivers and even have targeted case management available to assist some of our most at-risk recipients.

Case management is provided through a contract with the Alabama Department of Public Health (ADPH). ADPH has licensed and trained case managers available throughout the State. There are two types of available case management: EPSDT and Patient 1st adult. The distinction is made in that EPSDT case management is not governed by this waiver; yet many of the clients that it serves are also enrolled into the Patient 1st Program. For Patient

1st adult case management, any person can make a referral into the case management system on behalf of the patient.

Services provided are traditional case management services and include; assistance with understanding program requirements, help with transportation needs, assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols; mental health issues, child health issues such as understanding the need for preventive care, i.e. immunizations, etc.

Since Medicaid has several types of case management programs, services provided are distinguished by using specific procedure codes and modifiers. Further tracking is accomplished by assigning a specific invoice category for each procedure code and modifier combination.

Each patient that is referred into the case management system receives a risk assessment. Areas assessed include social supports, community supports, shelter/ nutrition/ communication resources, economic status, education/ language needs, physical health, mental health, parenting history and children's issues. From the risk assessment, a plan of action is developed in conjunction with the patient. Follow-up from the assessment and/or plan of action is provided back to the person making the referral into the system. ADPH is paid per time spent with the patient.

The State also has the ability to make direct referrals into the case management system. During the period of April 1, 2010 through June 30, 2010 there were 1683 referrals made for issues such as; excessive emergency room use, patient dismissal and patient education. In that State staff has contact with the patient, oftentimes issues are identified that may be preventing the patient from optimizing their medical home. Common reasons include lack of program understanding, transportation needs, and medical compliance. In the coming renewal period, the State will continue case management referrals for excessive emergency room utilization. By having the ability to talk one on one with a patient, the State can better determine why the patient is utilizing the emergency room versus seeking care from their PMP.

Pilot Network Care Management

The Agency seeks to improve the quality of care and health outcomes for its recipients. This includes improved clinical and functional status, enhanced quality of life, improved client safety, client autonomy, adherence to treatment plans, and control of fiscal growth/cost savings. The Network Care Management Program will address the following:

- Treatment regimens for chronic illnesses with better performance to evidence-based guidelines
- Network Care Managers will be more aware of and incorporate knowledge of functional assessments, behavioral changes,

motivational interviewing techniques, self-care strategies, and methods of addressing emotional and social distress as part of comprehensive patient care. Care will be less fragmented and more holistic (i.e., in addressing physical and behavioral health care needs and in considering both medical as well as social needs), and there will be better communication across settings and providers.

- Consumers will have greater involvement in their care. The Networks must have measurable outcomes related to changes in recipient care including but not limited to service utilization, costs, and improvements in Performance Measures

The objectives of the Network Care Management Program are to:

1. Develop and implement patient centered holistic plans of care;
2. Improve quality of care and quality of life;
3. Improve health literacy, health outcomes and self management;
4. Improve utilization of Information Technology resources by participants and providers in the program as available;
5. Promote effective use of the healthcare system and community resources;
6. Reduce the potential for risks of catastrophic or severe illness;
7. Prevent disease exacerbations and complications;
8. Integrate use of evidence-based clinical practice guidelines into program practices to ensure the “right care at the right time”; and
9. Reduce inappropriate utilization and costs associated with Emergency Department, and hospital inpatient services.

In the pilot districts, the Network will receive all referrals for Care Management. The Chronic Care Clinical Champion/Care Manager Supervisor will utilize the Care Management Screening Form to determine the appropriateness of care management through the networks or referral for other supports including Alabama Department of Public Health (ADPH) Care management.

A web based Informatics System is being developed for documentation and tracking of outcomes. ADPH will also be required to utilize this system for documentation of care delivery. This will provide coordination of care and prevent duplication of services.

Hemophilia Management Program

In addition to traditional case management services, the State has identified Hemophilia as a chronic condition that needs more intensive level of services and case management. The following is the Agency’s plan for providing services, resources and care to this population.

In order to be paid for providing blood clotting factor to Alabama Medicaid recipients, the outpatient pharmacy provider must agree to provide, at the

minimum, the following clinically appropriate items and services to their patients with hemophilia and blood clotting factor-related diseases:

(1) Home or office delivery of blood clotting factor and supplies. All shipments/delivery of clotting factor, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment.

(2) Educational materials and programs.

(a) The provider shall develop a training library at each enrolled provider location with materials for patient use, to include but not limited to, audio, video, electronic, and written materials.

(b) The provider shall offer educational materials to patient or family/caregiver at minimum at initiation of participation with the provider, yearly during the in-home assessment, and upon the request of Medicaid, the prescribing physician, or patient or family/caregiver.

(c) Topics of education shall include, but not be limited to, specific patient and family/caregiver education aimed at preventing injury that would result in a bleed, self-administration and reconstitution of blood clotting products.

(3) Medically necessary ancillary supplies required to perform the actual IV administration of clotting factor. Supplies may be billed to Medicaid through the Durable Medical Equipment (DME) program. In addition, sharps containers and any other necessary biohazardous waste containers shall be provided, as well as pickup and disposal of waste containers according to national, state and local biohazardous waste ordinances.

(4) Emergency telephone support 24 hours a day, 7 days a week to ensure patients are directed appropriately for care in emergent situations.

(5) For the purposes of this Rule and the Alabama Medicaid Agency hemophilia management standards of care, “clinical staff trained in hemophilia and related blood clotting factor related diseases” is defined as follows:

(a) Pharmacists are required to obtain a minimum of 2 Continuing Education (CE) credit hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

(b) Nurses and social workers are required to obtain a minimum of 4 Continuing Education (CEU) hours per year (8 hours every 2 years) that are specific to hemophilia or related blood clotting factor-related diseases.

Continuing education must be specific to hemophilia or related blood clotting factor-related diseases and recognized by a state or national hemophilia or bleeding disorder education/support group (for example: Hemophilia Federation of America or the National Hemophilia Association).

(6) Emergency delivery of blood clotting factor within 24 (with a target of less than 12) hours of the receipt of a prescription for a covered person's emergent situation, or notification of the patient with an existing valid prescription. Emphasis should be placed during patient education of the importance of keeping an adequate supply on hand and self-administration for emergent situations.

(7) A pharmacist, nurse, and/or a case representative assigned to each patient. A case representative shall maintain, at a minimum, monthly telephone contact with the patient or family/caregiver to include, but not limited to:

- Inquiry regarding patient's current state of well-being
- Assessment of patient/family compliance/adherence, and persistence with the medical treatment plan
- Incidence of adverse events
- Incidences of supply or equipment malfunctions
- Home inventory check of factor and supplies
- Confirmation of next delivery date

Case representatives may include administrative support staff, but must coordinate with clinical staff (as described in (5) above) in the event a clinical issue should arise.

(8) Compliance programs.

(a) The provider must assess patient adherence on monthly telephone contact (see (7) above) and on all in-home visits by a pharmacist, nurse, or case manager.

(b) The provider must verify the amount of clotting factor the patient has on hand prior to each dispense. Blood clotting factor and related products are not to be sent to the patient on an auto-ship basis. The provider shall discourage "stockpiling" of product.

(c) The number of bleeds and infusions from the prior shipment shall be tracked to validate the need for additional product or non-compliance with the medical treatment plan.

(9) Notification of product recalls or withdrawals.

(a) Any stock of recalled medications/equipment/supplies shall be removed from stock and quarantined immediately.

(b) Any recalled items dispensed to patients shall be retrieved and quarantined; notification to patients must occur within 24 hours of the recall receipt.

(c) The prescribing physician shall be notified of a medication recall. A prescription for an alternative product shall be obtained, if necessary.

(10) Visiting clinical services.

(a) At minimum, an initial and subsequent yearly in-home assessment of the patient, family/caregiver, and environment shall be conducted by a nurse or pharmacist trained in blood clotting factor related diseases.

(b) Additional in-home assessments of the patient, family/caregiver, and environment deemed necessary by the physician or patient situation shall be conducted.

(c) Visits may be provided directly by the provider or by arrangement with a qualified local home health care agency. All hemophilia-related clinical staff must be trained in hemophilia and bleeding disorder related diseases.

(11) A registered pharmacist trained in blood clotting factor related diseases to perform assay to prescription management. Variance in assay to prescription/target dose should not exceed +/- 10%.

(12) Adverse drug reaction and drug interaction monitoring and reporting. Pharmacists shall report any issues or concerns related to the patient's medications to the physician. For significant events, utilization of the FDA 3500 MedWatch voluntary reporting form is encouraged.

(13) Continuation of Care. The provider shall not present any bill to or collect any monies from a covered Medicaid recipient with whom the provider has agreed to the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia, except as follows:

(a) to collect the copayments/coinsurance amounts the covered person is required to pay under the terms defined by Medicaid, or

(b) if the service/product has been deemed "non-covered" and the recipient has been notified in advance as outlined in the Alabama Medicaid Agency Administrative Code and Provider Billing Manual.

Upon discontinuation of services by the provider, the provider shall, at a minimum, coordinate for another designated health care provider to provide services to covered persons, prior to withdrawal of any hemophilia-related services from the home of any covered person. The provider shall continue to provide services and supplies to a covered individual until the individual obtains an alternate source of services and supplies. Every effort shall be made by the provider (including notification to the Medicaid Director of Pharmacy) to find an alternative provider to ensure that the coordination of care/transition follows the minimum standards of care as set forth in this document.

Maternity Care Program

Home Visits

PREFACE: Home visits through the Maternity Care Program will become an optional service and at the discretion of the individuals involved in the woman's care. The program will allow flexibility for the Care Coordinator to make home visits based on the assessment and individualized needs of the recipient. A home visit will be required if the hospital face to face encounter is missed for any reason. The following criteria will be published as a guide in determining who may need to receive a home visit.

A. Under 16 Years of Age

- At time of conception
- Late entry into care (20 weeks gestation and over)
- Not residing in home with parents or spouse/significant other
- Grossly over weight or underweight
- Not in school
- Use of tobacco and/or alcohol and/or drugs
- Transportation issues
- Lack of support from family or father of baby
- Other triggers that may indicate a need for follow-up after delivery

B. Drug and Alcohol Abuse

- Self reported
- Psychosocial assessment
- Odor of alcohol
- Observations of track marks and/or bruises from needle use
- Unexplained late entry into care 20 weeks gestation and over
- At risk lifestyle (i.e., multiple sex partners)
- Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

C. Mental illness

- Postpartum depression (it is expected that these women may require a series of visits)
- Long term history of mental illness
- Taking psychotropic drugs for mental illness
- Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

D. Birthweight 2500 grams or less

- Prenatal care
- Previous birth outcomes
- Smoker
- Enrolled in a hospital follow-up program

E. Other – this category allows for flexibility in looking at individual patient needs.

Care Coordination

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a delivery system to ensure the most comprehensive program meeting the recipients' needs. It may involve one person or an entire team that has the responsibility of managing, assessing, planning, procuring, monitoring and evaluating the identified individual needs of the recipient.

Screening, Brief Intervention and Referral for Treatment for Alcohol and Substance Abuse

Screening, brief intervention and referral to treatment (SBIRT) for alcohol and substance abuse will be provided to pregnant women based upon the risk assessment which is completed by the delivering health care professional. The Department of Mental Health Substance Abuse Division will provide training to the delivering health care professionals. The training will focus on early identification of those individuals with nondependent substance use, education on how to provide effective strategies for intervention prior to the need for more extensive or specialized treatment and brief treatment within the community setting or referral for those identified as needing more extensive services. This will promote healthier birth outcomes.

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.

Patient 1st

The following services do not require a referral from the PMP:

- Independent Labs & Hospital Labs
- Mental Health Services
- Physicians: Anesthesiologists, Oral Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine
- Pregnancy-Related Services
- Independent Radiologists & Hospital Radiologists
- Targeted Case Management
- Ambulance
- Certified Emergency
- Dental
- Dialysis
- EEG/EKG Related Services
- End Stage Renal Disease
- EPSDT Development Diagnostic Assessment
- Routine Eye Exams
- Eyeglass & Other Lens Fittings
- Family Planning
- Diabetic Supplies
- Gynecology/Obstetrics Services
- Hearing Aids
- Hospice
- Immunizations
- Physician Inpatient Consults/Visits

- Inpatient Hospital Services (per diem)

Maternity Care Program

This program only covers pregnancy related services. Services must be provided for the purpose of supporting prenatal, delivery, or postpartum services. The following services while pregnancy related must be coordinated through the delivery health care professional, but are not the financial responsibility of the Primary Contractor. These services are reimbursed fee-for-service to the direct provider of service:

- Drugs
- Lab Services
- Radiology *with the exception of maternity ultrasounds*
- Dental – under 21
- Physician – Physician fees for family planning procedures, circumcision code, routine newborn care codes, standby and infant resuscitation code.
- Family Planning Services
- Emergency Services
- Transportation
- Services Provided for Dropout/Miscarriages
- Community Mental Health
- Referral to Specialists – Office or in hospital visits provided by non-OB specialty physicians.
- Non-Pregnancy Related Care
- Services provided by a physician associated with a teaching facility
- Inpatient Care

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.

N/A 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.

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

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

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

a. P1st **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. P1st PCPs (please describe): Patients always have the ability to change either their assigned or chosen PMP if travel is an issue. For this reason, the State does not have a maximum travel or distance standard. Each month the Agency sends out REOMBs

(Recipient Explanation of Medicaid Benefits) to survey recipients. The purpose of the REOMB is to identify problems the patient may be experiencing. Through the REOMB process, the Agency does monitor whether the patient can get to their doctors office within 45 minutes. 96% of patients said yes while only 4% reported no. Refer to Attachment Two for the actual REOMB tool and findings.

In addition to the REOMB process, patient change rates are also reviewed on a quarterly basis. The primary purpose is to look for patients who have changed three or more time in a six month period, but PMP trends are also reviewed to identify potential problems.

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

b. P1st **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. P1st PCPs (please describe): The PMP must conform to the following standards for appointment availability:
 - Emergency care – immediately upon presentation or notification
 - Urgent care – within 24 hours of presentation or notification
 - Routine sick care – within 3 days of presentation or notification
 - Routine well care – within 30 days of presentation of notification

The REOMB assesses whether appointment standards are being met.

Please refer to Attachment Two for complete details on the REOMB findings.

2. N/A Specialists (please describe):
3. N/A Ancillary providers (please describe):
4. N/A Dental (please describe):
5. N/A Mental Health (please describe):
6. NA Substance Abuse Treatment Providers (please describe):
7. N/A Urgent care (please describe):
8. N/A Other providers (please describe):

c. P1st **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. P1st PCPs (please describe): PMP must conform to the following standards for office wait times:
 - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
 - Scheduled appointment – within one hour
 - Life-threatening emergency – must be managed immediately

The Agency follows up on any complaints reported by patients regarding wait times. In these instances, staff tries to help the patient understand why they had to wait. If necessary staff may call the PMP's office to ensure wait times are not excessive or work with the recipient and PMP to reschedule the visit if there are unforeseen delays.

2. N/A Specialists (please describe):
3. N/A Ancillary providers (please describe):
4. N/A Dental (please describe):
5. N/A Mental Health (please describe):
6. N/A Substance Abuse Treatment Providers (please describe):
7. N/A Other providers (please describe):

d. N/A **Other Access Standards** (please describe)

N/A 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.

MCP 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.

N/A 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.

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

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

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

a. P1st The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

Each FTE (defined as 32 hours per week on-site) is allowed 1200 patients. Up to 2 physician extenders (e.g. nurse practitioner) can be used to extend the caseload to a max of 2000.

Clinic provider caseloads are determined by the total number of FTE physicians and physician extenders. Providers who have historically seen a higher caseload of Medicaid patients may be authorized a caseload

greater than 2000. As of submission date, there are only four individual PMPs with a caseload greater than 2000.

b. N/A The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State’s standard.

c. P1st 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. On a quarterly basis the State runs a report by county of participating PMPs by specialty. These numbers are then compared to the number and age distribution of enrollees for that county. If appropriate PMPs are not available, recruitment efforts will be undertaken.

d. N/A 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.

There is not an expected change in the number of providers from the current waiver period to those during the renewal period.

Specialty Primary	# In Current Waiver	# Expected in Renewal
	# Expected in Renewal	
FQHC (Clinic)	101	101
Rural Health Clinic (RHC)	123	123
Family Nurse Practitioner	4	4
Nurse Practitioner (Other)	151	151
Certified Nurse Midwife	1	1
Family Practitioner	470	470
General Practitioner	82	82
Nephrologist	14	14
Obstetrician/Gynecologist	20	20
General Pediatrician	437	437
Infectious Disease	13	13
Internal Medicine	269	269
Sum:	1,685	

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

- e. P1st The State ensures adequate **geographic distribution** of PCCMs. Please describe the State’s standard. Attachment Three is a count of PMPs within each county. Attachment Four is a listing of PMPs by the recipient county they serve. An additional column indicates the number of patients for the county and provides PMP to enrollee rates.
- f. N/A **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.

PMP County Code # of PMPs # of Enrollees PMP Ratio & Description

PMP County Code	# of PMPs	# of Enrollees	PMP Ratio
01 - Autauga	14	2,328	1:166
02 - Baldwin	27	15,130	1:560
03 - Barbour	9	2,643	1:294
04 - Bibb	4	2,867	1:717
05 - Blount	9	4,246	1:472
06 - Bullock	5	2,061	1:412
07 - Butler	5	4,453	1:891
08 - Calhoun	31	16,355	1:528
09 - Chambers	16	3,366	1:210
10 - Cherokee	5	2,822	1:564
11 - Chilton	4	4,342	1:1086
12 - Choctaw	5	1,751	1:350
13 - Clarke	11	5,246	1:477
14 - Clay	6	1,429	1:238
15 - Cleburne	4	614	1:154
16 - Coffee	14	5,054	1:361
17 - Colbert	21	8,215	1:391
18 - Conecuh	5	2,276	1:455
19 - Coosa	3	1,597	1:532
20 - Covington	16	6,054	1:378
21 - Crenshaw	3	1,148	1:383
22 - Cullman	15	8,705	1:580
23 - Dale	5	3,370	1:674
24 - Dallas	17	13,668	1:804
25 - Dekalb	15	8,617	1:574

26 - Elmore	12	5,245	1:437
27 - Escambia	17	5,099	1:300
28 - Etowah	38	13,333	1:351
29 - Fayette	7	1,691	1:242
30 - Franklin	13	4,463	1:343
31 - Geneva	6	2,224	1:371
32 - Greene	3	1,160	1:387
33 - Hale	2	2,118	1:1059
34 - Henry	3	987	1:329
35 - Houston	30	18,779	1:626
36 - Jackson	23	6,290	1:273
37 - Jefferson	159	78,256	1:492
38 - Lamar	3	1,185	1:395
39 - Lauderdale	17	7,163	1:421
40 - Lawrence	2	2,523	1:1262
41 - Lee	22	11,712	1:532
42 - Limestone	16	5,028	1:314
PMP County Code	# of PMPs	# of Enrollees	PMP
& Description			Ratio
43 - Lowndes	3	857	1:286
44 - Macon	4	3,359	1:840
45 - Madison	54	27,069	1:501
46 - Marengo	6	4,505	1:751
47 - Marion	9	4,665	1:518
48 - Marshall	22	14,485	1:658
49 - Mobile	44	54,134	1:1230
50 - Monroe	12	3,231	1:269
51 - Montgomery	41	36,982	1:902
52 - Morgan	24	11,467	1:478
53 - Perry	3	1,044	1:348
54 - Pickens	8	2,661	1:333
55 - Pike	10	5,623	1:562
56 - Randolph	8	2,586	1:323
57 - Russell	13	7,953	1:612
58 - St.Clair	16	6,597	1:412
59 - Shelby	25	6,545	1:262
60 - Sumter	6	2,209	1:368
61 - Talladega	22	13,297	1:604
62 - Tallapoosa	9	4,602	1:511
63 - Tuscaloosa	26	20,209	1:777
64 - Walker	20	9,151	1:458
65 - Washington	3	1,806	1:602
66 - Wilcox	4	1,415	1:351
67 - Winston	6	3,295	1:549

g. P1st **Other capacity standards** (please describe): The state monitors any complaints and grievances pertaining to an enrollee's difficulty in locating a PMP within their area. Two border counties in East Central Alabama, while having sufficient PMP capacity, have few specialty providers. This area also has providers who either move to more urban areas or do not accept Medicaid. Recruitment efforts are ongoing to encourage more physicians to accept Medicaid and to open up their patient caseload.

Additionally, the State has implemented a monitoring process to identify the PMP's reasons for dis-enrolling from the program. This information provides the State a mechanism to monitor loss in geographical areas and to determine what actions might be successful in retaining other providers.

N/A 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.

MCP 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.

N/A 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.

MCP 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.

The contract for the Maternity Care Program has not changed since waiver approval.

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

The following items are required.

- a. MCP 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. There is not a separate determination for enrollment with special health care needs. The State has defined individuals with special healthcare needs as individuals with on-going chronic conditions. The scope of services under this program is limited to pregnancy related. Case management is required for every enrollee. If special needs are found, there are mechanisms to address these needs through case management. In addition, if the woman's medical condition is such that it cannot or should not be treated through the Maternity Care Program, she can be exempted.
- b. N/A Identification. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.
- c. N/A Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
- d. N/A 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. N/A Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. N/A Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. N/A In accord with any applicable State quality assurance and utilization review standards.
- e. MCP Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Reimbursement for specialists is not included in the global fee paid to the Primary Contractor. However, if it is found to be pregnancy related it is paid fee for service.

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.

Note: Details on the enrollment process are included in Section C.

- a. P1st Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. N/A 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. N/A Each enrollee is receives **health education/promotion** information. Please explain.
- d. P1st Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. P1st There is appropriate and confidential **exchange of information** among providers.
- f. N/A Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. N/A 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. P1st **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).

If these services are provided to a Patient 1st enrollee, information on services is provided to the PMP by the case manager.

- i. P1st **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.

When making referrals, the PMP must provide the National Provider Indicator (NPI) number to be used by the consulting provider. All PMP referrals must be in writing. The PMP may make the referral verbally, but must follow with a written referral to the requesting physician within 72-hour period of the verbal authorization. The consulting physician is required to provide information regarding treatment to PMP.

PMPs may make referrals to any practitioner that can best meet the patient's needs, with effort made to refer patients to geographically appropriate Medicaid enrolled providers. Services authorized retroactively are at the discretion of the PMP.

The length of the referral is also at the discretion of the PMP. A PMP may authorize a single or multiple visits and even had the ability to allow another provider (e.g. specialist) to further refer on his behalf. The same authorization referral number is used for each treatment visit. It is the PMPs responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

The recipient does not have to be seen by the PMP prior to the PMP issuing/approving a referral.

N/A 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.

N/A 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.

N/A 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.

MCP 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.

The Maternity Care Program contract has not changed since the amendment was approved for an effective date of 1/1/10.

N/A 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 effective August 1, 2005. The quality strategy is part of the Operational Manual which was approved with the original waiver.

N/A 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):

The State is changed from a PIHP to a PAHP with the contract amendment effective 1/1/2010.. The last EQRO review was completed in March of 2010. This was a final 2010 report for 2008 data.

2. **Assurances For PAHP program.**

MCP 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.

N/A 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.

MCP 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. The maternity Care contract has had no changes since the amendment was approved for an effective date if 1/1/2010.

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. P1st The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach. The complete QA plan is detailed in Attachment Six.

b. P1st **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. P1st Provide education and informal mailings to beneficiaries and PCCMs;

2. P1st Initiate telephone and/or mail inquiries and follow-up;

3. P1st Request PCCM's response to identified problems;

4. P1st Refer to program staff for further investigation;

5. P1st Send warning letters to PCCMs;

6. P1st _ Refer to State’s medical staff for investigation;
7. P1st _ Institute corrective action plans and follow-up;
8. P1st _ Change an enrollee’s PCCM;
9. P1st _ Institute a restriction on the types of enrollees;
10. P1st _ Further limit the number of assignments;
11. P1st _ Ban new assignments;
12. P1st _ Transfer some or all assignments to different PCCMs;
13. P1st _ Suspend or terminate PCCM agreement;
14. P1st _ Suspend or terminate as Medicaid providers; and
15. P1st _ Other (explain):

The action taken is dependent on the level of the problem. Often problems reported by recipients can be managed through a telephone call to the PMPs office. Currently, the State’s most common “informal” complaint is “I cannot get a referral.” In these situations, an Agency staff person will call the PMP on behalf of the patient and resolve the matter. Education is provided to both the recipient and the provider regarding their responsibilities to one another through Patient 1st.

- c. P1st _ **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. N/A _ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. N/A _ 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. N/A 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. N/A Initial credentialing
 - B. N/A Performance measures, including those obtained through the following (check all that apply):
 - N/A The utilization management system.
 - N/A The complaint and appeals system.
 - N/A Enrollee surveys.
 - N/A Other (Please describe).
4. N/A 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. N/A 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. N/A Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. P1st Other (please describe).

Providers wishing to serve as a PMP must be a Medicaid enrolled provider. In addition to the regular Medicaid application, a separate agreement must be completed for participation in the Patient 1st Program. Any provider can elect to participate, even a specialist, if they are willing to meet program requirements.

d. N/A **Other quality standards** (please describe):

N/A 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 criterion is weighted:

Section A: Program Description

Part IV: Program Operations

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.

NA 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.

There have been no changes in the Maternity Care Program contract since the amendment effective 1/1/2010 was approved.

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

2. Details

a. **Scope of Marketing**

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

2. N/A The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the

MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

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

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

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

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

N/A 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.

The maternity care Contract has not changed since the approval of the Waiver amendment effective 1/1/10.

N/A 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. X The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

Patient 1st

The Agency has worked to translate eligibility information as well as covered services information. However, this is sometimes a difficult process due to the different dialects spoken by our recipients.

Many provider offices have software available to help the patient understand office policies, physician directives and can be used to explain Medicaid requirements.

The Agency maintains a 1-800 Recipient Call Center number to assist patients with program needs. This unit handles general program inquiries as well as Patient 1st specific needs. If a patient needs to change their assigned PMP or seeks information on PMPs in their area, staff is available.

Maternity Care Program

Primary Contractors throughout the state have translated their program specific information into Spanish. This is also available at the program level, a Spanish version of the recipients Rights and Duties which explains to the patient program requirements.

1. N/A The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
2. N/A Other (please explain):

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

The Agency maintains a contract with a language line service that has the ability to translate any language and/or dialect. There is one main 1-800 number advertised as the number to call to contact Medicaid. The operators manning this line are trained on how to assist non-English speaking individuals by connecting them with the language line. Providers also have the ability to refer patients to this 1-800 number for language assistance.

The Medicaid District offices also have installed a language assistive device known as “Prolingua”. It is a computer based multilingual communication device that assists with Medicaid application completion.

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

As explained earlier, the State maintains a Recipient Call Center. This unit is available to explain program requirements. Additionally, program

information is provided at the time of Medicaid application. Program information is always available in the Agency's website and provides the ability for recipients to change their PMP via an electronic PMP change form and order replacement Medicaid cards. The Agency has made great strides in revamping its webpage to provide up to date information on all available services, the various programs and even how to apply for Medicaid. The Agency promotes the website at every opportunity with both providers and recipients and the web address.

For the Maternity Care Program, Primary Contractors are required to have enrollment staff understand the requirements of the program.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

 X State
 contractor (please specify) _____

 MCP 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
- (ii) MCP State contractor (please specify): The Primary Contractor.
- (iii) the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

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

N/A 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.

There have been no changes in the Maternity Care Program contract since the amendment was approved for an effective date of 1/1/10.

N/A 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. X **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:

Patient 1st

Potential enrollees are educated about the Patient 1st Program at the time of Medicaid eligibility as well as through the enrollment packet. Providers are informed of the ability to enroll as a Patient 1st provider via the Medicaid website and information contained in the regular Medicaid enrollment packet. Outreach and education is provided by program staff as needed and requested by providers. As stated earlier the State's webpage is heavily promoted as a resource for information as well.

Maternity Care Program

Information that is provided at the time of application and specific district information is also provided at the time of eligibility determination. A brochure has been developed by the state outlining the districts throughout the state and provides direct access information for each district. A copy of the brochure is available on our website.

b. Administration of Enrollment Process.

X State staff conducts the enrollment process.

N/A 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:

N/A choice counseling

N/A enrollment

N/A other (please describe):

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

Participation in both programs is mandatory. Beneficiaries in Patient 1st, however, do have the ability to choose their provider. The MCP Primary Contractor is required to perform this function. The MCP Primary Contractor provides a list of all participating delivering physicians in the district to the recipient and the recipient chooses their delivering health care professional.

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

N/A 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.):

N/A 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.):

P1st If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

- i. ___ Potential enrollees will have ___ days/month(s) to choose a plan.
- ii. P1st 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 Agency automatically assigns enrollees to PMPs based on proximity and the following algorithm: newborn, sibling, past PMP, historical claims and random. Recipients who are added to the Medicaid eligibility file are notified of their Patient 1st assignment approximately 45 days prior to effective date of the assignment. The purpose of the 45 day lead time is to allow recipients to change providers prior to actual PMP assignment. A listing of all providers serving that patient’s county is included in the enrollment packet and is maintained on the Agency’s website. A second notification is mailed to recipients approximately 5 days prior to assignment, which confirms the original assignment if no change is made. Providers are also notified on a monthly basis of all patients on their panel including information on those who have been disenrolled. The assignment process takes into account the group practices and/or clinic affiliation.

The State randomly samples assignments to ensure that the assignment process is working correctly. The assignment reason is compared to the information on file to ensure that the most appropriate assignment algorithm was applied.

The following illustrates the assignment ratio for the enrollees.

PMP County Code & Description	# of PMPs	# of Enrollees	PMP Ratio
01 - Autauga	14	2,328	1:166
02 - Baldwin	27	15,130	1:560
03 - Barbour	9	2,643	1:294
04 - Bibb	4	2,867	1:717
05 - Blount	9	4,246	1:472
06 - Bullock	5	2,061	1:412
07 - Butler	5	4,453	1:891
08 - Calhoun	31	16,355	1:528

09 - Chambers	16	3,366	1:210
10 - Cherokee	5	2,822	1:564
11 - Chilton	4	4,342	1:1086
12 - Choctaw	5	1,751	1:350
13 - Clarke	11	5,246	1:477
14 - Clay	6	1,429	1:238
15 - Cleburne	4	614	1:154
16 - Coffee	14	5,054	1:361
17 - Colbert	21	8,215	1:391
18 - Conecuh	5	2,276	1:455
19 - Coosa	3	1,597	1:532
20 - Covington	16	6,054	1:378
21 - Crenshaw	3	1,148	1:383
22 - Cullman	15	8,705	1:580
23 - Dale	5	3,370	1:674
24 - Dallas	17	13,668	1:804
25 - DeKalb	15	8,617	1:574
26 - Elmore	12	5,245	1:437
27 - Escambia	17	5,099	1:300
28 - Etowah	38	13,333	1:351
29 - Fayette	7	1,691	1:242
30 - Franklin	13	4,463	1:343
31 - Geneva	6	2,224	1:371
32 - Greene	3	1,160	1:387
33 - Hale	2	2,118	1:1059
34 - Henry	3	987	1:329
35 - Houston	30	18,779	1:626
36 - Jackson	23	6,290	1:273
37 - Jefferson	159	78,256	1:492
38 - Lamar	3	1,185	1:395
39 - Lauderdale	17	7,163	1:421
40 - Lawrence	2	2,523	1:1262
41 - Lee	22	11,712	1:532
42 - Limestone	16	5,028	1:314
PMP County Code	# of PMPs	# of Enrollees	PMP Ratio
& Description			
43 - Lowndes	3	857	1:286
44 - Macon	4	3,359	1:840
45 - Madison	54	27,069	1:501
46 - Marengo	6	4,505	1:751
47 - Marion	9	4,665	1:518
48 - Marshall	22	14,485	1:658
49 - Mobile	44	54,134	1:1230
50 - Monroe	12	3,231	1:269
51 - Montgomery	41	36,982	1:902
52 - Morgan	24	11,467	1:478

53 - Perry	3	1,044	1:348
54 - Pickens	8	2,661	1:333
55 - Pike	10	5,623	1:562
56 - Randolph	8	2,586	1:323
57 - Russell	13	7,953	1:612
58 - St.Clair	16	6,597	1:412
59 - Shelby	25	6,545	1:262
60 - Sumter	6	2,209	1:368
61 - Talladega	22	13,297	1:604
62 - Tallapoosa	9	4,602	1:511
63 - Tuscaloosa	26	20,209	1:777
64 - Walker	20	9,151	1:458
65 - Washington	3	1,806	1:602
66 - Wilcox	4	1,415	1:351
67 - Winston	6	3,295	1:549

MCP The State **automatically enrolls** beneficiaries
N/A on a mandatory basis into a single MCO, PIHP, or PAHP in
a rural area (please also check item A.I.C.3)
MCP 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)
N/A 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: _____

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

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

Patient 1st

The Patient 1st Program is based on the premise that patient care is best
served by a medical home where a Primary Medical Provider (PMP) may
coordinate care. If in the physician's opinion, the patient does not benefit

from the Patient 1st Program, an exemption can be requested. Common reasons are:

- **Terminal Illness** (**Note:** The enrollee has a six month or less life expectancy and/or is currently a hospice patient.)
- **Impaired Mental Condition** which makes it impossible for the adult enrollee to understand and participate in Patient 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.)
- Currently undergoing **Chemotherapy** or **Radiation treatments**. (**Note:** Exemption for this is temporary and will end with the completion of the therapy).
- **Diagnosis/Other information:** (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)

Either the PMP or the attending physician can submit this request on behalf of the patient. These are classified as medical on the number of exemptions.

Maternity Care Program

The purpose of a program exemption is to allow a recipient to receive care outside the established Maternity Care Program District.

The following are standard exemption reasons:

Medical Necessity – If the patient has a high risk pregnancy that the subcontracting physician believes cannot or shall not be treated by the Primary Contractor Network and determines that continuous obstetrical specialty care is needed by an out-of-plan provider, a medical exemption can be requested.

Medicaid Eligibility Granted Late in Pregnancy – When the recipient applies for and receives Medicaid eligibility late in her pregnancy (3rd trimester) or after delivery and has been receiving continuous care through a non-subcontracted provider, a program exemption can be requested.

TPL – if the patient has an HMO type insurance that requires that care be received from certain providers and those providers are not part of the Maternity Care network, an exemption can be requested.

Procedure For Exemption – The recipient or provider shall request an exemption from the Primary Contractor prior to delivery on the standardized program exemption form. The state reviews the requests. If approved, an indicator is placed on the system for all claims to bypass the Maternity Care edits. If denied, the provider and/or patient can request reconsideration.

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.

Patient 1st reassigns the patient to the last PMP on file regardless of the time lapse. NOTE: Maternity patients retain eligibility throughout the pregnancy.

d. Disenrollment:

P1st The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. P1st Enrollee submits request to State.

ii. N/A 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. N/A Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

MCP 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.

N/A The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

X 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.

Patient 1st

There are no restrictions in Patient 1st.

Maternity Care Program

Within the first 90 days of enrollment in the Maternity Care Program, a patient can change her chosen physician for no cause. After the initial 90 days, the patient can change, but cause must be stated.

P1st The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i. P1st MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

A PMP may request removal of a recipient from his panel due to good cause. All requests for patients to be removed from a PMP's panel should be submitted in writing and provide the enrollee 30 days notice. The request should contain documentation as to why the PMP does not wish to serve as the patients's PMP. Good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired.
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1st enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

ii. P1st The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

The State does not approve the request; rather tracking is done on both the PMP and recipient to identify potential trends. The recipient may be referred for care coordination service as well. The State is specifically tracking for PMPs who may be dismissing patients without good cause.

iii. N/A 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.

Note: The PMP requesting disenrollment is responsible for notifying the patient that he/she is being dismissed. A copy of that letter is sent to the State.

iv. P1st 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.

N/A 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.

The Maternity Care contract has not changed since the amendment that was approved for an effective date of 1/1/10.

N/A 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.

N/A 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.

N/A 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.

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

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

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

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

N/A 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

MCP 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).

MCP The State’s timeframe within which an enrollee must file a **grievance** is ? days. The State does not limit the timeframe.

c. Special Needs

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

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

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

- P1stX The grievance procedures is operated by:
 - X the State
 - the State’s contractor. Please identify: _____
 - the PCCM
 - the PAHP.

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

The State utilizes the following definitions:

1. Grievances: Written communications explicitly addressing dissatisfaction about any matter other than an action which may include the following: the availability, quality, payment, treatment, reimbursement of claims for services, and/or unresolved issues through the complaint process.

2. Appeal: a request for review of an action.

An action is defined as:

- The denial or limited authorization of a requested service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a services
- The failure to provide services in a timely manner
- The failure of the entity to act within timeframes provided in 438.408

The following are the type grievances filed regarding the Patient 1st Program that have been received from October 2008 through September 2010:

Service Related	122
Access to care	7
Potential quality of care	7

The following are the type grievances filed regarding the Maternity Care Program that have been received January 2010 through September 2010:

Unhappy with Staff	18
Transportation	36
Appointment wait times	6
Medical/MD	29
Communication issues	21
Other	17

X 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.

The Quality Assurance staff have combined with program administration staff to better coordinate monitoring activities as well as provide continuity of communication within the program.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: 60 (please specify for each type of request for review)

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

X Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process_15 days.

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

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

N/A 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**

N/A 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.

N/A 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.

N/A 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.

N/A 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.

The Maternity Care Program converted from a PIHP to a PAHP with the amendment effective date of January 1, 2010. There have been no changes to the Maternity Care contract since 1/1/2010.

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data	MCP		X			X	X		X	X	X	X
Data Analysis (non-claims)												
Enrollee Hotlines	X				X							
Focused Studies												MCP
Geographic mapping							P1st	P1st	P1st			
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by							MCP	MCP				

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
Plan												
Ombudsman												
On-Site Review	MCP					MCP	MCP	MCP	MCP	MCP	MCP	
Performance Improvement Projects												
Performance Measures	MCP		MCP				MCP	X	X			X
Periodic Comparison of # of Providers	MCP							P1st				
Profile Utilization by Provider Caseload				P1st								P1st
Provider Self-Report Data	MCP											
Test 24/7 PCP Availability							P1st					
Utilization Review												MCP
Other: (describe)		N/A										

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II. Details of Monitoring Activities

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

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

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

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

- NCQA
- JCAHO
- AAAHC
- Other (please describe)

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

- NCQA
- JCAHO
- AAAHC

X Other (please describe) Providers must be Medicaid enrolled providers to participate in the programs. Provider enrollments are done by HP Medicaid's fiscal agent. As part of the enrollment process licensing and certification is accomplished. By requiring the provider be enrolled, the State can be assured that the provider is qualified. As part of the routine enrollment process, there is assurance that the provider has also not been sanctioned.

c. X Consumer Self-Report data

- CAHPS (please identify which one(s))

Note : The Agency is currently putting systems into place to obtain CAHPS surveys.

X State-developed survey The State utilizes REOMBS to survey patients about services received. Attachment Two contains information on the REOMB process.

- Disenrollment survey
- Consumer/beneficiary focus groups

- d. X Data Analysis (non-claims)
- Denials of referral requests
 - Disenrollment requests by enrollee
 - From plan
 - From PCP within plan
 - X Grievances and appeals data – both programs have grievance processes that have been explained in detail.
 - PCP termination rates and reasons
 - Other (please describe)

- e. X Enrollee Hotlines operated by State
The State, through its fiscal agent, maintains a recipient call center. Recipients can call the toll free number for program information, including; changing their PMP in the Patient 1st program, request replacement Medicaid cards, contact Agency staff to address specific needs or to report any problems.

- f. MCP 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). Focus studies for (April - June 2007) were required and Primary Contractors identified through their own QA issues topics that would fit their areas. Topics were Pre-term delivery and Recipient Education Plan. The purpose of the focus study, Pre-term Delivery, conducted by 3 Districts, was to determine if additional care coordination encounters, for mothers who have had a previous pre-term delivery, will decrease the number of repeat pre-term births in these mothers. The purpose of the focus study, Recipient Education Plan, conducted by 11 Districts, was to determine if education efforts were effective. Information from the above studies was utilized in performance improvement projects designed to assess the effectiveness of the education efforts of the Districts in both studies.

- g. X Geographic mapping of provider network

For both programs, the State closely monitors provider accessibility.

Maternity Care Program

As part of the ITB process, potential bidders are required to provide the geographic distribution of all their subcontractors. The program requirement is that women should not have to travel more than 50 miles to a delivering healthcare professional.

Patient 1st

The State, on a quarterly basis, runs a report ensuring that there is an adequate number of the appropriate type PMPs necessary to serve recipients in each county. This ensures that access to care is not being impaired. Additional information on access is contained in Section A.II.B.2.

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

The last assessment was completed in November 2008. We have completed two waiver periods and interpret that this is no longer required.
- i. NA Measurement of any disparities by racial or ethnic groups
- j. MCP Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]
At time of initial contract award and anytime there is a change in the provider network, the Primary Contractor is required to notify Medicaid.
- k. NA Ombudsman
- l. MCP On-site review
Onsite administrative audits are conducted of the Primary Contractors. The purpose of the audit is to review billing and disbursement records; exemption files, subcontracts; care coordinator licensing requirements and to have the opportunity to review and document first hand program operations.
- m. N/A Performance Improvement projects [**Required** for MCO/PIHP]
 Clinical
 X Non-clinical – refer to f above
- n. N/A Performance measures [**Required** for MCO/PIHP]
 Process
 Health status/outcomes
 Access/availability of care
 Use of services/utilization
 Health plan stability/financial/cost of care
 Health plan/provider characteristics

Beneficiary characteristics

The following are the performance measures that are gathered by the State based on medical record reviews.

- *To increase the % of pregnant women who began prenatal care during the first 13 weeks of pregnancy*
- *To decrease the % of low birth weight babies born to Medicaid mothers*
- *To decrease the % of very low birth weight babies born to Medicaid mothers*
- *To increase the % of Medicaid mothers who had live births that completed a postpartum visit to a healthcare provider on or the 60th postpartum day*
- *To increase the % of pregnant women smokers who quit smoking while pregnant*
- *To increase the % of Medicaid mothers who had live births that underwent the recommended # of prenatal visits*
- *To increase the number of pregnant diabetic women who have at least one session with a registered dietician*
- *To increase the % of Medicaid mothers who breast feed*
- *To increase the % of completed required postpartum hospital face to face visits that adequately addresses the needs of the Medicaid mother and baby*
- *To decrease the number of births prior to 37 weeks gestation*

A random sample of 5% of deliveries is reviewed bi-annually for each district. The review period is for deliveries occurring within a previous six month period. There is a lagtime to allow for completion of the postpartum visit. Upon completion of the review, each district receives their individual findings as well as statewide averages. The statewide averages are computed utilizing a weighted district average to present a more accurate measurement due to the variation in the volume of deliveries per district.

- o. N/A Periodic comparison of number and types of Medicaid providers before and after waiver
- p. P1st Profile utilization by provider caseload (looking for outliers)

The Agency has finalized the Profiler which is our physician report card. A sample Profiler is Attachment Five. The purpose of the Profiler is to provide the PMP with utilization and cost information with regard to their panel and as compared to their peers. The information on the Profiler is designed to supply the PMP with specific information in the area of pharmacy and emergency room utilization. It is sent on a quarterly basis to the PMPS reporting a year's worth of data.

On the last page are the performance measures that the Agency will be using to share savings with the PMP. As earlier explained, the Agency has committed to share at least half of the program savings with those PMPS that achieved selected program goals.

- q. N/A Provider Self-report data
___ Survey of providers

___ Focus groups

- r. P1st Test 24 hours/7 days a week PCP availability
To ensure that PMPs are meeting the requirement for providing 24/7 coverage, a random 25% sample of PMPs is pulled monthly. From this information, a phone call is placed after regular office hours to assess what system is in place to provide 24/7 coverage. Of the sample, the PMPs chosen must indicate an arrangement to meet the 24/7 coverage requirement; excluding the local emergency room unless the PMP has an agreement with the facility to provide this service. Any provider found to be out of compliance is contacted and requested to provide a corrective action plan as necessary and may have the case management fee for this component suspended.
- s. P1st Utilization review (e.g. ER, non-authorized specialist requests)
Through the Patient 1st Program, PMPs receive two utilization reports. The first is the "Referral Report." This report lists all claims that were paid as a result of the PMP's referral (NPI) number being used. The PMPs are asked to review the report to ensure that all referrals were appropriate. Follow up and education regarding the appropriate referral process is completed on all providers using the PMPs referral number without authorization. This may include recoupment of monies paid from submission of these claims.
- The second report is Emergency Room Management Report. This report provides information on patients who are utilizing the emergency room including what emergency room and the diagnosis. PMPs are asked to review this information and educate patients on inappropriate emergency room use. Program staff may also refer recipients for case management if misuse of the emergency room is suspected. Additionally, hospitals may be referred to the Agency's Provider Surveillance Unit for inappropriate certifications of emergency room visits are suspected.
- t. N/A Other: (please describe)

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.

NA 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:
Enrollee hotlines are not a measurable activity; therefore, they are not addressed below.

1. Strategy: REOMBS (Patient 1st and Maternity Care Program)

Confirmation it was conducted as described: REOMBS for both programs are sent on a monthly basis. Attachment Two details the individual REOMBS and provides the results.

Yes

REOMBS are sent to approximately 1,250 to 1,500 Patient 1st enrollees throughout the state on a monthly schedule and 708 MCP participants on a monthly basis. The return rate runs about 16.5% for MCP and 31% for Patient 1st.

No. Please explain:

Summary of results: Refer to Attachment Two.

Problems identified: There continues to be a less than optimal response rate for REOMBS.

Corrective action (plan/provider level): One way the Agency is addressing this is by simplifying the questions and answers which requires less of the recipient's time to complete. The State's WEB page has been of increased value as more recipients utilize this tool to contact program staff about issues that are addressed in the REOMB questionnaire. This gives the Agency the ability to gain data being sought through REOMBS while handling issues in "real" time. The State will continue to explore ways to increase response rates.

Program change (system-wide level): None.

2. Strategy:

Maternity Care Program (MCP) Performance Improvement Project (PIP)

Confirmation it was conducted as described:

Yes -

All fourteen districts completed the requisite (PIP) Performance Improvement Projects and submitted their findings.

No. Please explain:

Summary of results:

With the Performance Improvement Projects (PIP) of fiscal years 2006-2008 each District addressed their individual results and developed specific interventions toward improvement of their findings. The basis for the 2006 PIP study, Late Entry into Care, was to identify ways to increase entry into prenatal care. Each District was able to identify and implement individual interventions to increase entry into care.

Two PIP topics were addressed during fiscal year 2007. One PIP, Pre-term Delivery, sought to determine if additional care coordination encounters for mothers who had a previous pre-term delivery would decrease the number of repeat pre-term births in those mothers. The "Pre-Term Delivery" PIP began 1/1/08 and was completed on 6/30/08 with three districts participating in this project. A 51 % repeat rate was identified prior to entering into the PIP Pre-term delivery. The PIP Pre-term delivery data revealed that out of the 25 eligible moms entered into the study , 10 delivered pre-term, (before 37 weeks). This resulted in a 40% repeat rate of the patients entered into the study. It was concluded that with the additional education provided improved the pre-term repeat rate by 11%. As a result of this, a teaching strategy was implemented on a permanent basis for those Districts.

Eleven Districts chose to do a PIP on Effectiveness of the Recipient Education Plan. All Districts sited increased comprehension of educational material improves patient education and compliance, promoting optimal birth outcomes. Districts were able to identify educational needs within their areas and upon implementation of plans, were able to better educate recipients on the Maternity Care Program, and normal expectations during their prenatal and postpartum periods.

All Districts showed an increase in correct responses with the additional education during the PIP phase. Questions regarding the warning signs of pregnancy had a correct response increase from 72.5 % to 89% and from a 52% to 100% regarding actual impending labor with three districts. Other areas of concerns addressed by Districts for improvement in recipient education were the positioning of an infant, SIDS, and nutrition. All were identified as needing to be a priority for all recipients.

With both PIPs, the goal was to improve the recipient's knowledge which would facilitate our goal of delivering healthy babies. Results of PIPs and interventions will be considered for implementation of future Statewide PIPs in the areas of Late Entry into Care, Smoking Cessation Education and Breastfeeding Education.

Problems identified:

A deficiency in recipient knowledge regarding how and when to enter care was identified with Late Entry into Care. Identified with Recipient Education was a need to increase recipient knowledge in areas of nutrition, labor and delivery, the Maternity Care Program and Sudden Infant Death Syndrome. With the PIP Pre-term delivery validation of education efforts in one area was not possible due to very small number (2) of patients in their area with previous pre-term births. Valuable information was obtained with each PIP there is a need to develop a statewide PIP topic in one or more of the areas identified in these two PIPS.

Corrective action (plan/provider level):

Conduction of Statewide PIPs. The first PIP will be addressing the "5 A" Counseling Method of Smoking Cessation. The first project period will be 10/01/08 with results due 7/31/09.

Program change (system-wide level):

The findings of the individual districts in the next Statewide PIPs will determine whether program changes are necessary.

3. Strategy: Geographic Mapping of Provider – Maternity Care Program

Confirmation it was conducted as described:

Yes - This is done as part of the ITB review process and readiness reviews are that are conducted prior to contract implementation for the Maternity Care Primary Contractors.

No. Please explain:

Summary of results: All Primary Contractors were able to provide access to delivering healthcare professionals within 50 miles/50 minutes of women within their district.

Problems identified: None.

Corrective action (plan/provider level): At time of bid award, if a Contractor cannot meet network requirements, the bid is found non-responsive. Anytime there is a change in the network, the 50 mile/50 minute requirement is applied.

Program change (system-wide level): None.

4. Strategy: Geographic Mapping of Provider – Patient 1st Program

Confirmation it was conducted as described:

Yes - On a quarterly basis the State runs a PMP listing by PMP county and by recipient county to ensure that there is adequate access. The numbers are then compared to the number of patients in that county.

No. Please explain:

Summary of results: No problems of access have been identified.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

5. Strategy: Independent Assessment (Patient 1st and Maternity Care Program)

Confirmation it was conducted as described:

Yes

Contracting for this activity will be put out for bid and is expected to be completed November 2008.

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level):

Program change (system-wide level):

6. Strategy: Network Adequacy Assurance Submitted by Plan (Maternity Care Program)

Confirmation it was conducted as described:

Yes - Refer to 3 in this section.

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level):

Program change (system-wide level):

7. Strategy: On-Site Review (Maternity Care Program)

Confirmation it was conducted as described:

Yes - Annually, each Primary Contractor receives an on-site review. Areas reviewed include billing and disbursement, exemption files, subcontracts, and care coordinator licensing requirements. The on-site review also gives the State the opportunity to review and document first hand program operations.

No. Please explain:

Summary of results: To date no problems have been identified. Primary Contractors have been found to meet program requirements in all areas.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

9. Strategy: Performance Measures (Maternity Care Program)

Confirmation it was conducted as described:

Yes - This function is conducted bi-annually by Quality Assurance staff.

___ No. Please explain:

Summary of results: For the period of time July 2006 through June 2008, 2,059 records were reviewed. The results are charted below:

Maternity Care Program					
July 06- June 08					
Measure	Base-line	Goal	Statewide 1/06-12/06	Statewide 1/07-12/07	Statewide 1/08-12/08
To increase the % of pregnant women enrolled in Medicaid who began prenatal care during the first 13 weeks of pregnancy.	65%	75%	61%	62%	63%
To decrease the % of low birth weight babies born to Medicaid mothers.	10%	9%	9%	10%	10%
To increase the % of women who had live births who had a postpartum visit to a healthcare provider on or between 21 days and 56 days after delivery.	60%	65%	69%	71%	67%
To increase the % of pregnant women who smoke or recent quitters who received advice to quit smoking from a health professional.	85%	95%	98%	96%	97%
To increase the % of very low birth weight babies born to Medicaid mothers	2%	1%	2%	1%	2%
To increase the % of completed required postpartum home visits made to Medicaid mothers.	80%	85%	46%	51%	43%
To increase the % of completed required postpartum home visits that adequately addresses the needs of the Medicaid mother and baby.	60%	75%	79%	86%	86%
To increase the % of Medicaid enrollees who had live births during the past year who underwent the	80%	85%	78%	79%	77%

recommended number of prenatal visits.					
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Problems identified: None

Corrective action (plan/provider level): None

Program change (system-wide level): None

10. Strategy: Profile Utilization (Patient 1st)

Confirmation it was conducted as described:

Yes No. Please explain: The Agency has finalized the Profiler. The information contained allows the PMP to see panel specific utilization as well as an “expected” calculation. The expected utilization is morbidity adjusted to allow the PMP a comparison of how “his peers” would treat his panel. System programming has been requested to include proposed performance measures which would begin 1/1/09. The run of the Profiler will continue to be on a quarterly basis.

Summary of results: See Attachment Five

Problems identified: The main problem is getting providers to review the information in the report. It is a lengthy report but contains a significant amount of data regarding the providers practice trends.

Corrective action (plan/provider level): The Agency is considering training contract staff that currently travels across the state so they can discuss the report as they visit providers. Also, consideration is being given to reducing the length of the report so providers can get the information “at-a-glance”

Program change (system-wide level): None

11. Strategy: Test 24 hours/7 days a week (Patient 1st)

Confirmation it was conducted as described: The State runs a report of counties to be monitored for the month which lists the PMPs in those counties and the contact information they indicated for their 24/7 access. The providers are contacted after hours and on weekends to verify this coverage. If coverage is not acceptable the provider is notified, in writing, of the results of the monitoring call and a corrective action plan (CAP) is requested outlining the steps they will take to come into compliance. Once a CAP is approved, a monitoring call is then placed to verify the plan is working.

Yes No. Please explain:

Summary of results: The State has monitored providers in 62 of the 67 counties in Alabama for a total of 375 providers. Of these, 62 were notified their 24/7 coverage was inadequate in meeting program standards and were asked to submit a corrective action plan (CAP). Forty plans have been received and approved with verification calls made. Other monitoring results include: 16 providers opted out of the 24/7 case management fee component, one provider is in the process of sending in a CAP and 5 providers have ended their enrollment in Patient 1st.

Problems identified: Provider’s lack of adequate 24/7 coverage.

Corrective action (plan/provider level): When the State identifies any provider who is out of compliance the provider is asked to submit a corrective action plan to provide this coverage. A monitoring call is placed to verify the coverage. The case management fee for this component may be suspended if coverage is not adequate.

Program change (system-wide level): 24/7 coverage is considered to be the foundation for a medical home, therefore the State will make this a mandatory requirement of program participation during the next waiver period.

12. Strategy: Utilization Review (Patient 1st Program)

Confirmation it was conducted as described:

Yes - The *Emergency Room Management Report* is sent out on a monthly basis to PMPs.

No. Please explain:

Summary of results: As a result of the report being sent out, PMPs are calling to report that they are following up with patients. The Agency also uses this report to monitor providers who may be diverting recipients to the Emergency Room when the PMP is not available after hours. Another use is to identify those hospitals that certify an inordinately large amount of Emergency Room visits. Education is provided to both the PMPs and hospitals regarding these practices and the consequences of mismanagement; including recoupment of fees and the suspension of case management fees. A process has been formalized to refer recipients for recipient review and/or case management as well.

Problems identified: None

Corrective action (plan/provider level): None

Program change (system-wide level): None

Yes - The *Referral Report* is sent out on a monthly basis to PMPs.

No. Please explain:

Summary of results: The PMP reviews the Referral report to determine if any services were not authorized. The PMP contacts program staff via telephone or fax to report discrepancies. Program staff reviews the discrepancies and if found to be valid, corrective action is taken.

Problems Identified: Getting the PMP to take the time to review this information has been an issue. Some providers feel very strongly about unauthorized referrals for their recipients; therefore they are very diligent about notifying the Agency when this happens. Some provider, however, do not see it as a problem or they don't take the time to review the report.

Corrective Action: The Agency educates providers when there is phone contact, through articles written in the Agency's "Provider Insider" periodical and when visits are made to providers by our fiscal intermediary staff.

Program change (system-wide level): The State will continue to work to promote use of the report.

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

- Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
Robert Church
- c. Telephone Number: (334) 353-3310
- d. E-mail: robert.church@medicaid.alabama.gov
- e. The State is choosing to report waiver expenditures based on X date of payment.
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

- B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*
- a. X The State provides additional services under 1915(b)(3) authority.
- b. The State makes enhanced payments to contractors or providers.
- c. The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

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

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

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

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

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

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

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

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

- a. Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 1. First Year: \$ 2.60 per member per month fee
 2. Second Year: \$ 2.60 per member per month fee
 3. Third Year: \$ _____ per member per month fee
 4. Fourth Year: \$ _____ per member per month fee

Primary Care Physicians (PMPs) will receive a per enrollee monthly case management fee, which will vary from doctor to doctor based on the number and type of management services they provide. The following table reflects the components of the monthly case management fee. Case management will be available to all MEGs except the SOBRA Adult.

- 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.

Each Care Network will receive a PMPM fee based on the eligibility category of each enrollee:

\$3.00 PMPM for anyone that is not aged, blind or disabled
 \$5.00 PMPM for each aged blind and disabled individual.

- c. X 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.

The Agency distributed a portion of the money saved through the collective efforts of Patient 1st providers. The savings is based on the previous two year waiver period. A total of \$5,756,300 in 2007 was shared with 1,021 PMPs out of a total of 1,088. The average check totaled \$5,638. The largest amount paid was \$133,538 and the lowest amount paid was \$1.69.

In 2009, \$4,900,000 was shared based on a performance pool and an efficiency pool. The distribution of shared savings is based on a formula designed by the Mercer actuarial firm to equitably reflect several measures of performance and efficiency. Efficiency reflected the actual amount Medicaid spent on behalf of a PMP's panel compared to the expected expenditures. Performance measures were the actual utilization by the PMP's panel compared to what was expected.

The following are the current performance measures and the related rationale for each:

PERFORMANCE MEASURES

Performance Measures	Rationale
Emergency Room visits (certified and non-certified)	One goal of Pt. 1 st is the reduction of unnecessary ER utilization
Number of Hospital days per 1000 patients	The effective management of recipients outside the hospital setting, especially those with chronic conditions, by the PMP is expected to result in improved patient outcomes.
Percent of Generics utilized	One goal of Pt. 1 st is the reduction of pharmacy expenditures resulting from increased generic utilization.
Percent of Asthma patients who have had one or more ER visits with the primary	Quality measure aligning Pt 1 st with established TFQ measures

diagnosis of Asthma	
Percent of Diabetic patients who have had at least one HbA1c test during review period	Quality measure aligning Pt 1 st with established TFQ measures
EPSDT for 0-5 population	Reinforces the medical home concept.
Office Visits per Unique Enrollee	Carried over from last waiver period. Reinforces the medical home concept.

CMS will approve the shared savings methodology during each waiver period before it can be implemented.

d. ___ Other reimbursement method/amount. \$_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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

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

For Conversion or Renewal Waivers:

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

- b. __ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: **Increases and decreases are not unusual for the various MEGs over time. Per the Terms and Conditions of the amendment effective 08/01/08, the state is including a separate Hemophilia MEG. These eligibles have been removed from the other MEGS, where they were previously included.**
- d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P2: ___
- e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **calendar years 2009 and 2010.**

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**:

-
- 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: **Since eligibles receiving long term care services will not be enrolled in this waiver, the following services were excluded from the cost-effectiveness analysis: nursing facility care, ICF/MR, nursing facility-MD, MR/DD waiver, MR/Living At Home waiver, Elderly & Disabled waiver, Hospice, Homebound waiver, and Medicare HMO. On advice of the Regional Office, the State also excluded inpatient psychiatric hospital. The State also excluded targeted case management for the medically at-risk, since this service was a 1915(b)(3) under the previous PCCM waiver.**

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

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

For Initial Waivers:

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

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>			
Total			

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). **Only those administrative costs directly associated with the waiver were included.**

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>			
Total			

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
Patient 1 st Case Management	\$ 3,955,310 or \$ 0.73 PMPM in R1 \$ 3,073,832 or	3.3% in P1	\$ 3,175,268 or \$ 0.48 PMPM in P1 \$ 3,280,052 or

	\$ 0.52 PMPM in R2	3.3% in P2	\$ 0.46 PMPM P2
Patient 1 st Home Health	\$ 523,133 or \$ 0.10 PMPM in R1 \$ 922,492 or \$ 0.15 PMPM in R2	43.3% in P1 43.3% in P2	\$ 1,321,851 or \$ 0.20 PMPM in P1 \$ 1,894,097 or \$ 0.26 in P2
Hemophilia Management Program	\$1,941,230 or \$4,817 PMPM in R1 \$ 3,428,482 or \$ 5,313 PMPM in R2	43.38% in P1 43.38% in P2	\$ 4,915,734 or \$6,559 PMPM in P1 \$ 7,048,145 or \$8,330 PMPM in P2
Care Network Fee	\$.00 or .00 PMPM in R1 \$ 0.00 or \$ 0.00 PMPM in R2		\$1,328,622 or \$0.25 PMPM in P1 \$3,152,820 or \$0.58 PMPM in P2
SBIRT	\$.00 or .00 PMPM in R1 \$ 4,011 or \$ 0.00 PMPM in R2	3.3% in P1 3.3% in P2	\$ 4,143 or \$0.00 PMPM in P1 \$ 4,280 or \$0.00 PMPM in P2
Total	\$ 6,744,164 or \$ 1.24 PMPM in R1 \$7,774,180 or \$ 1.30 PMPM in R2		\$ 11,111,437 or \$ 1.68 PMPM in P1 \$ 15,766,880 or \$ 2.20 PMPM in P2

The Pregnancy Risk Assessment Monitoring Assessment (PRAMS) is a surveillance system of new mothers and is supported by the Centers for Disease Control and Prevention (CDC). The Alabama PRAMS Surveillance Report of 2006 contains information and statistical data which links the negative behaviors of smoking and alcohol to poor birth outcomes.

The report indicates that 15.4% of mothers continue to smoke during pregnancy. The CDC has indicated that the single most preventable cause of illness and death among mothers and infants is smoking. The PRAMS report also references that 8% of infants who die within one week after birth expire due to conditions caused by maternal smoking during pregnancy. Additionally, the report supports those babies born to mothers who smoke are more prone to low birth weights.

The report also provides statistical information on Alabama mothers who use alcohol before and during their pregnancy. The information links low birth weight infants to these negative maternal behaviors. The State feels that providing these new B3 services of screening, brief intervention and referral for treatment of drug and alcohol use will promote healthier birth outcomes.

The cost savings are achieved through the current cost-effective reimbursement methodology in the maternity program. The maternity global payment to primary

contractors includes pregnancy associated ultrasounds, estimated to be 3% of the global fee (\$75). $\$75 \times 30,000 \text{ deliveries} = \$2,250,000$.

Under the fee for service reimbursement methodology the statewide average costs for three ultrasounds per pregnancy are as follows: $\$120.00$ (average costs per ultrasound) \times 3 ultrasounds per pregnancy $= \$360 \times 30,000 \text{ deliveries} = \$10,800,000$.

This results in a savings of $\$8,550,000$ which is more than adequate to cover the expenses for all B3 services.

Telemetry Monitoring and Smoking Cessation were removed from B(3) services and added to State Plan services effective 6/1/2011. The cost effectiveness spreadsheets were calculated by removing the $\$0.06$ PMPM for Telemetry Monitoring for P1 and P2 for B(3) services and increasing State Plan services by $\$0.06$. No reductions or additions were made to B(3) or State Plan services for Smoking Cessation since these costs were minimal and no PMPM charge was experienced.

- b.____ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

Basis and Method:

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

d. X 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.

As previously stated, the Agency collaborated with stakeholders to adopt new performance measures upon which the distribution of shared savings will be based. As the amount of the savings and the methodology of distribution is not yet known, the Agency did not place amount in for “FFS incentive costs.”

The Agency will submit a revised Schedule D when the amount and methodology have been determined. Document the method for calculating incentives/bonuses, and

Maternity Care Program

This contract adopts primary contractor incentive payments based on performance of specific outcomes and process measures on an annual basis. Please refer to the list of the specific measures listed on page 11.

The State is initiating performance incentive measures to primary contractors of up to 5% of the primary contractor’s payments for the Fiscal Year. The Contract start date is January 1, 2010. The State is requiring the primary contractor to use a state wide data base system to report information. The state will use this data base as well as record review to support compliance with the measures listed below. If the documentation supports the measures the State will make a payment to the primary contractor. Each measure carries a different weighted payment amount. The Contractor may qualify for payment of any one of the measures. The first payment is scheduled for three months following the first contract which will be April 2011. The incentive measures are as follows:

- a. The primary contractor must have documentation to support that 5% of the smoking mothers enrolled for care ceases smoking during the pregnancy and continue to cease until the postpartum visit. The State will utilize the electronic database and the routinely scheduled record reviews for monitoring compliance. If this measure is supported the district will receive 1% of their first year of payments for the fiscal year.
- b. The primary contractor must have established or maintained one Centering pregnancy site during the first year. The State will require the primary

contractor to submit documentation of the site to the State. At the end of the first contract period, the State may physically visit the site to support this requirement. If this measure is supported the district will receive .5% of their first year of payments for the fiscal year.

- c. The Primary Contractor must have documentation that supports that that 50% of all diabetic women enrolled have at least one session with a registered dietician by the end of the second trimester. The State will utilize the electronic database and the routinely scheduled record reviews for monitoring compliance. If this measure is supported the district will receive .5% of their first year of payments for the fiscal year.
- d. The Primary Contractor must have documentation to support 85% of all delivering women complete a family planning visit by the 60th post partum day. The district will be required to submit documentation of such visits to the State by the end of the first contract year. If this measure is supported the district will receive 1% of their first year of payments for the fiscal year.
- e. The Primary Contractor must have medical record documentation to support a minimum average of 11 prenatal visits per recipient per total number of paid deliveries. The State will utilize the electronic database and the routinely scheduled record reviews for monitoring compliance. If this measure is supported the district will receive 0.5% of their first year of payments for the fiscal year
- f. The Primary Contractor must have medical record documentation to support that a minimum of 25% of the total number of delivering mothers are identified to be breast feeding at the post partum visit. The State will utilize the electronic database and the routinely scheduled record reviews for monitoring compliance. If this measure is supported the district will receive 0.5% of their first year of payments for the fiscal year.
- g. The primary Contractor must have medical record documentation that supports that 75% of the total number of deliveries occurring within the district annually completes the first doctor’s visit at < 14 weeks gestation. The State will utilize the electronic database and the routinely scheduled record reviews for monitoring compliance. If this measure is supported the district will receive 1% of their first year of payments for the fiscal year.

District	Global times deliveries
District One	\$2473 x 1283=\$3,172,859
District Two	\$2753 x 3794=10,444,882
District Three	\$2302 x 2258= 5,197,916
District Four	\$2380 x 1657 =3,943,660
District Five	\$2475 x 6543= 16,193,295
District Six	\$2,477 x 1220 = 3,020,371
District Seven	\$2180 x 214 = 466,520
District Eight	\$2440 x 393=958,920
District Nine	\$2180 x 774 =1,687,320
District Ten	\$2286 x 3392= 7,754,112

District Eleven	\$2765 x 1687 = 4,664,555
District Twelve	\$2316 x 2185 = 5,060,460
District Thirteen	\$2541 x 1652 = 4,197,732
District Fourteen	\$2159 x 3565 = 7,696,835
TOTALS	74,461,636 x 2.5% = 1,861,540.

We do not anticipate that any given district will meet all the measures. The above chart depicts a projection which is a conservative estimate of 2.5% to all the 14 districts. Based on the actual review, the State may have to make an adjustment in these cost projections.

ii. 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.

The State will monitor the quarterly 64.9 Waiver submissions to ensure that the total payments to PMPs in P1 do not exceed the Waiver Cost Projection.

2. X 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**)

Current Initial Waiver Adjustments in the preprint

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

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

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

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

1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
2. ___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated 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 _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

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

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

Others:

- Additional State Plan Services (+)
 - Reductions in State Plan Services (-)
 - Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)
1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
 2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ **Determine adjustment for Medicare Part D dual eligibles.**
 - E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- iv. ___ Changes in legislation (please describe):
- For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. ___ **Administrative Cost Adjustment***: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

- 1. ___ No adjustment was necessary and no change is anticipated.
- 2. ___ An administrative adjustment was made.
 - i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

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

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

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
 - 1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to*

present). The actual documented trend is: _____. Please provide documentation.

- 2.____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
 1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.
 - 1.____ We assure CMS that GME payments are included from base year data.
 - 2.____ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
 - 3.____ Other (please describe):

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

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

Method:

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

- g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.
1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
 2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
 3. ___ The State had no recoupments/payments outside of the MMIS.
- h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
- Basis and Method:*
1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
 2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
 3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
 4. ___ Other (please describe):
- If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.
1. ___ No adjustment was necessary and no change is anticipated.
 2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.
- Method:*
1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
 2. ___ Determine copayment adjustment based on pending SPA.
 3. ___ Determine copayment adjustment based on currently approved copayment SPA.
 4. ___ Other (please describe):
- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will

delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

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

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

Basis and Method:

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

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

1. ___ We assure CMS that DSH payments are excluded from base year data.

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

1. **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: $\text{PMPM Waiver Cost Projection} - \text{PMPM Actual Waiver Cost} = \text{PMPM Cost-effectiveness}.$)

- 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 2005 to present*) The actual trend rate used is: variable by MEG. Please document how that trend was calculated: **As in the previous waiver renewal, the claims for each MEG were obtained from the Agency's query system. However, there are payments and recoupments that are outside of the claims system. These amounts were obtained from the Fiscal Division and then apportioned because they are not tied to any particular eligibility group. The apportionment is based on the percentage of overall Pt 1st member months compared to total Medicaid member months. This percentage was multiplied by the amount of the payment/recoupment to obtain the amount attributable to the Pt. 1st population. The amount for each MEG was then calculated based on the percentage of each MEG's member months of the total Pt 1st member months. The amounts paid for (b)(3) services were not included in the calculation of the FFS trend rate. The claims and payments/recoupments were added together to obtain a total cost for each MEG. The amounts were then divided by each MEGs member months for R1 and R2.**

The trend rate for each MEG was calculated by using the percent difference between CY 2009 and 2010. If the percent difference was negative then the Global Insight market basket inflation percentage of 3.3 % for 2007 to 2010 was used for the inflation adjustment rate. This methodology was used for P1 and P2.

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 **January 2009 to December 2010**. 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. The trend rate for each MEG was calculated by using the percent difference between CY 2009 and 2010. If the percent difference was negative then the Global Insight market basket inflation percentage of 3.3 % for 2007 to 2010 was used for the inflation adjustment rate. This methodology was used for P1 and P2.
 - 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. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.
- b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:**
 These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted

above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

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

1. X The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ___ An adjustment was necessary and is listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). 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):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
 - iv. ___ Changes brought about by legal action (please describe):

For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
- For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. ___ **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. **X** Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe: **There will be**

an External Quality Review Organization utilized in P1 and

P2. ii. X Cost increases were accounted for.

- A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
- B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. Other (please describe): **Personnel costs were obtained through the Fiscal Division. Printing and mailing cost were obtained through the Fiscal Agent Division. Other administrative costs, such as the EQRO, were submitted by Program staff for Pt 1st and Maternity Care. The administrative costs for R1 and R2 were calculated separately for Pt 1st and Maternity Care. The amounts were apportioned to each MEG based upon the percentage of claims for that MEG of the total FFS claims. For Maternity Care, it was the percentage of the total Maternity Care claims. The apportioned amounts for Pt 1st and Maternity Care were added together to obtain the total R1 and R2 administrative costs for each MEG.**

To obtain the adjustment factors for P1 and P2, R2 was used as the base year. The EQRO will only be for Maternity Care and will be paid in P1. Personnel costs were inflated by 3.3 % for P1 and P2. Printing and mailing costs for R2 were multiplied by the Global Insight market basket inflation percentage of 3.3%. for P1 and P2. The percent change from The following table illustrates the calculation of the administrative cost adjustment factor.

	R2 Actual Costs	Projected P1 Costs	Adjustment Factor
Staff:	\$ 820,078	\$ 847,141	3.3%
Printing/Mailing	\$ 414,409	\$ 428,084	3.3%
EQRO		\$ 48,000	
TOTAL	\$ 1,234,487	\$ 1,323,225	6.71%
	Projected P1 Costs	Projected P2 Costs	Adjustment Factor

Staff	\$ 847,141	\$ 875,097	3.3%
Printing/Mailing	\$ 428,084	\$ 442,211	3.3%
EQRO	\$ 48,000	\$48,000	
TOTAL	\$ 1,323,225	\$ 1,365,307	6.71%

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

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

- 1. **X** [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 2005 to present*). The actual documented trend is: 16.4% for P1 and P2. Please provide documentation. The (b)(3) services offered through this waiver for Pt. 1st are home health visits and case management, for the Maternity Care Program, screening for alcohol and drug use, brief

intervention and referral for treatment. and the hemophilia management program

The costs for the screening, brief intervention and referral for treatment services were obtained from projections in collaboration with the Department of Mental Health. **The costs for the home health visits and case management were obtained through the query system. The costs for the home visits were obtained from reports submitted by the Maternity Care contractors. The furnishing fee is calculated based upon how many units of hemophilia drugs are paid by the pharmacy program.** For B3 services, CY 09 and 10 were compared and the percent difference was used to calculate adjustment rate for each MEG. If the percent difference was negative, the Global Insight market basket inflation percentage of 3.3% for 2007-2010 was used for the inflation adjustment rate. The same methodology was used to calculate the PMPM for P2.

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
- i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
 - ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above
- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG :
 2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** N/A
 3. Explain any differences: The Agency expects to make a one time payment in P1 to providers, but the amount and methodology has not yet been determined; therefore, no trend rate is applicable.
- 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. X Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix D5**.
 2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
 3. ___ Other (please describe):

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 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: Growth and declines for each MEG will follow historical trends.**

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 were not analyzed to aid in determining adjustments. Instead, the State chose to develop trends which did not separate changes in unit costs, utilization, practice patterns, technology, or other factors contributing to overall changes in PMPM expenditures.**
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: See our response to 2. above.**

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 spreadsheet in Attachment Seven.