

Facesheet: 1. Request Information (1 of 2)

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

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

Short title (nickname)	Long title	Type of Program
IBHP	Integrated Behavioral Health Program	PIHP;
BHSO	Behavioral Health Services Only for Fully Integrated Managed Care Region	PIHP;

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

Washington State Integrated Community Behavioral Health Program

C. **Type of Request.** This is an:

Amendment request for an existing waiver.

The amendment modifies (Sect/Part):

1. Adds SUD Peer Counseling as a service.
2. Moves the North Sound RSA to the integrated model.
3. Updates Cost Effectiveness.

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

1 year

2 years

3 years

4 years

5 years

Draft ID:WA.036.10.03

D. **Effective Dates:** This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Approved Effective Date of Base Waiver being Amended: 07/01/17

Proposed Effective Date: (mm/dd/yy)

07/01/19

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

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

Name:

Richard VanCleave

Phone:

(360) 725-3703 Ext: TTY

Fax:

E-mail:

vancrlr@dshs.wa.gov

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

The State contact information is different for the following programs:

Integrated Behavioral Health Program

Name:

Richard VanCleave

Phone: (360) 725-3703 Ext: TTY

Fax:

E-mail:

vancrlr@dshs.wa.gov

Behavioral Health Services Only for Fully Integrated Managed Care Region

Name:

Cyndi Presnell

Phone: (360) 725-0764 Ext: TTY

Fax:

E-mail:

cyndi.presnell@hca.wa.gov

waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.

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

The Department of Social and Health Services (DSHS), Aging and Disability Services, Behavioral Health and Service Integration Administration (ADS/BHSIA) complies with Section 1902(a)(73) of the Social Security Act (the Act), and has met the Tribal Consultation Requirements under the Act as specified in the Washington State Medicaid State Plan, TN #11-25, effective July 1, 2011.

The information below applies to the original waiver. The attached Tribal Notice was sent and Tribal consultation is pending.

A joint notification from HCA and DSHS was sent to Tribal Leaders, Indian Health Services, Tribal 638 Facilities, and Urban Indian Health Organizations regarding the State's intent to submit a waiver renewal for the Integrated Community Behavioral Health Programs on 4/8/16. The letter included:

- A request & due date for review and comment;
- Notification that the due date for the Waiver renewal was 7/30/16
- A statement that the Waiver amendment as approved for 1/1/16, exempts American Indians/Alaska Natives (AI/ANs) from the managed care delivery system (Behavioral Health Organization or BHO) system for substance use disorder (SUD) services but includes AI/ANs in the BHO system for mental health care services for those that meet the access-to-care standard;
- The following anticipated impact statement: Through Tribal comments and Tribal consultations related to the Waiver amendment, effective date 4/1/16, HCA and DSHS understand that, by mandatorily including AI/ANs in the BHO managed care system for mental health services, the Waiver (prior to the amendment) has had a number of impacts on AI/ANs and the Indian Health Service, Tribal 638 Facilities, and Urban Indian Health Organizations (together, the I/T/Us), including challenges with involuntary treatment of I/T/U clients, separate assessments for authorization of payment for Medicaid covered services, agreeing on crisis coordination plans, and access to culturally appropriate services.
- To mitigate the impacts related to mandatorily including AI/ANs in the BHO managed care system for mental health services, HCA and BHA agreed with the Tribal Representatives to do the following:
 - Provide written communication to BHOs and providers clarifying that all providers do not need a contract to make referrals for SUD assessments or intakes for AI/AN Medicaid enrollees (5/16);
 - Amend the Behavioral Health Services Contracts between DSHS and the BHOs to require BHOs to establish a standardized referral process for I/T/Us for mental health (In process);
 - Prepare a budget request for the 2017-19 legislative session to fund Tribal Designated Mental Health Professional (DMHP) designation, training, and service delivery (Completed 6/16);
 - Work with Tribes to:
 - oSupport a pilot of Tribal DMHPs with the Chehalis Tribe (In process);
 - oConsult with Tribes regarding submission of a State Plan Amendment to add residential programs on the IHS facilities list as a covered benefit under the IHS encounter rate (completed 6/16);
 - oDevelop a data review process and identify strategies for improvement for inpatient mental health treatment (In process);
 - oDevelop a decision package and request legislation for a Tribal E&T facility (completed 6/16).
 - oProvide contact information of key state staff for tribal questions to be directed to (completed 6/16)

The Tribes and State have been working together for the last nine to ten years to improve access to behavioral health services for American Indians and Alaska Natives. Recent Roundtable (R) meetings and Consultations (C) were held jointly with HCA and DSHS on:

- 10/30/15 (R)
- 11/10/15 (R)
- 11/17/15 (C)
- 3/25/16—Follow Up Meeting
- 4/7/16 (C) with CMS
- 4/25/16 (R)
- 5/23/16 (R)
- 6/3/16 (C)
- 6/22/16 (C)
- 10/26/16 (C)
- 12/5/16 (C) on 1115 Waiver (STCs for 1915(b) Waiver were discussed also)
- 2/27/17 (R)
- 3/9/17 (C)

As a result of the discussions held through Tribal roundtable and Consultation, all parties including CMS recognized the AI/AN population to be able to choose SUD and mental health services through FFS or this waiver. To allow time for the Tribes and State to engage in meaningful discussion to develop a mutually agreed upon plan for moving forward the State requested a 90-

day extension on the current waiver amendment. This 90-day extension moves the expiration date of the current waiver from 9/30/16 to 12/31/16 in effect moving the waiver renewal submission date to 9/30/16. In December 2016, the State was granted another extension until 6/30/2017. Another Tribal consultation was held on 3/9/17.

HCA and DSHS have continued to meet with Tribal Governments and I/T/Us and have come to agreement on language for the waiver renewal that reflects the plan a behavioral health FFS model for the AI/AN population by 7/1/17. This waiver renewal will not impede efforts by the Tribes and the State to develop a tribal-centric behavioral health service system that is carved out of managed care. HCA and DSHS are committed to continued work with Tribal Governments and I/T/Us through the Monthly Tribal Meetings (MTM) and subgroup meetings as needed to achieve the goals set forth.

The Tribes continue to express concerns similar to those previously identified for the waiver amendment. The state understands the concerns raised by Tribes to be 1) Continued and equal access for tribal members to substance use disorder residential treatment and; 2) agreed upon crisis coordination plans between Tribes and the regions; 3) lack of representation of Tribes on Governing Bodies for the BHOs. DSHS and HCA have continued to work with the Tribes through the roundtable and Consultations to address these concerns. DSHS and HCA will be working with the tribes to establish a FFS Behavioral Health Program for the AI/AN population by July of 2017 and will plan to do a waiver amendment to carve the AI/AN population out of BHO regions for all behavioral health services.

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).

HCA as the single state Medicaid agency is responsible for approving rules, regulations, and policies that govern how the State Plan and waivers are operated. Previously, HCA delegated waiver submission and other authorities to DSHS. As of July 1, 2018 HCA reassumed all authorities and activities previously delegated to the Division of Behavioral Health and Recovery (DBHR) within DSHS. This change occurred through an agency integration process in which many DBHR staff and program responsibilities were subsumed under HCA.

The Washington legislature (RCW 71.24.850) set forth two pathways for the integration of behavioral health and physical health care by January 1, 2020. The first task for the state was to establish Regional Service Areas (RSAs) that would be used for all federal and state Behavioral Health care purchasing to begin April 1, 2016.

Beginning in 2016, regions may become Fully Integrated Managed Care Regional Service Area and adopt a purchasing model in which care for Medicaid beneficiaries is delivered through contracts between the Health Care Authority and Managed Care Organizations for both medical and behavioral health (mental health and substance use disorder services); or, Counties may establish Behavioral Health Organizations (BHOs) as Prepaid Inpatient Health Plans and adopt a purchasing model in which care for behavioral health (mental health and substance use) disorders for Medicaid beneficiaries is delivered through contracts between the HCA and the BHOs. As the state continues to expand Fully Integrated Managed Care (FIMC), other RSAs will become part of the fully integrated delivery system. These managed care entities contract with service providers to deliver integrated care in each RSA.

Each RSA must contain a sufficient number of Medicaid lives to support full financial risk managed care contracting for services, be made of counties that are contiguous with each other, and reflect natural referral patterns and shared service resources.

Beginning April 1, 2016, counties in nine of the 10 RSAs began adopting a purchasing model in which behavioral health care for Medicaid beneficiaries is delivered through contracts with the BHOs and physical health services will be purchased under separate managed care contracts with MCOs or provided through fee for service. The former RSN system became the BHO delivery system for behavioral health. The contracts between DSHS for the provision of outpatient substance use disorder services (SUD) on a fee-for-service basis, and the current direct contracts between DSHS and SUD residential treatment services, were terminated effective March 31, 2016. In the tenth RSA, the Health Care Authority (HCA) began contracting with MCOs (for clients enrolled in Apple Health managed care) and with PIHPs (for clients who receive physical health care outside of Apple Health managed care). HCA became responsible for the full continuum of physical and behavioral health services for clients in these “integrated” regions. On January 1, 2018, the North Central RSA became the second region to adopt the FIMC model, leaving eight BHO regions and two “integrated” regions.

This amendment will move the North Sound Regional Service Area into the fully integrated model.

In addition to the regional integration efforts described above, on 1/1/2019 the state made changes to managed care behavioral health services for children in foster care. The state legislature, through SHB 2530, required HCA to move all services for foster care children (behavioral and physical health) into a single managed care organization by January 1, 2019.

Behavioral Health Organizations

As Prepaid Inpatient Health Plans (PIHPs), the BHOs contract for direct services, provide utilization management and other administrative functions, and develop quality improvement and enrollee protections for all Medicaid clients enrolled in the BHO system. The BHOs contract with local providers to provide an array of behavioral health, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan. The capitated managed behavioral health system gives the BHOs the ability to design an integrated system of mental health and substance use disorder care and subcontract with networks of Community Behavioral Health Agencies capable of providing quality service delivery, which is age and culturally competent. This contractual structure is expected improve behavioral health service outcomes and help to control the rate of financial growth while still requiring adherence to all state and federal requirements. BHOs may impose additional requirements on subcontractors as needed to ensure appropriate management oversight and flexibility in addressing local needs.

The BHOs also work cooperatively with Apple Health managed care organizations (MCOs) to ensure coordinated care for enrollees. Apple Health is Washington’s medical Medicaid-funded managed care program which covers a full array of medical services as well as a mental health benefit for those who do not meet the Access to Care Standards for mental health services

provided by the BHOs.

Behavioral Health Services Only

In the FIMC regions, HCA will contract with at least two current Apple Health managed care entities, selected through a competitive Request for Proposal (RFP) to deliver integrated health care as PIHP entities.

Most Medicaid enrollees in the FIMC regions will be enrolled in the Apple Health Fully Integrated Managed Care program, including all current Apple Health managed care enrollees. The remaining enrollees will be mandatorily enrolled in the Behavioral Health Services Only (BHSO) component of the FIMC integrated contracts.

This waiver is intended to authorize the mandatory enrollment into the BHSO of the remaining enrollees who are not mandatorily enrolled in the FIMC through either the state plan under section 1932(a). These remaining enrollees will continue to receive physical health medical services through other delivery systems, such as HCA's fee-for-service system, Medicare, or primary care case management.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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

- a. **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
-- *Specify Program Instance(s) applicable to this authority*

IBHP

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

IBHP

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

IBHP

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

IBHP

BHSO

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

MCO

PIHP

PAHP

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

FFS Selective Contracting program

Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

- a. Section 1902(a)(1) - 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.
-- *Specify Program Instance(s) applicable to this statute*

IBHP

BHSO

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

IBHP

BHSO

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

IBHP

BHSO

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

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

IBHP

BHSO

- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

Non-competitive Procurement - HCA relies on the agreement with the Centers for Medicare and Medicaid Services (CMS) that, in accordance with State law, the Regional Support Networks (RSNs) transition to Behavioral Health Organizations (BHOs), have the first opportunity to contract to operate the PIHP for outpatient behavioral health services (mental health and substance use disorder) and community mental health inpatient and residential substance use disorder services.

The state began purchasing substance use disorder services primarily through managed care contracts on April 1, 2016 as mandated in RCW 71.24.380. Behavioral Health Organizations (BHOs) will replace the current RSNs and County operated Substance Use Disorder programs. BHOs were required to submit a detailed plan demonstrating capacity to serve the Medicaid populations; if an adequate plan was submitted, the BHO was awarded the contract in that region.

Pursuant to the State's Community Mental Health Services Act, RCW 71.24., which defines BHO as a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region, county-based BHOs administer all community behavioral health services funded by the state. Previously, under other state statutes, the counties played a key role in substance use disorder treatment services and will continue to play a key role in the delivery of services for people with developmental disabilities. All BHOs must meet the certification requirements of RCW 71.24 and RCW 48.44 (the insurance code), as applicable.

If a BHO chooses not to participate, or is unable to meet required qualifications, the state will secure an alternate contractor through a competitive procurement process.

For the BHO regions

Section 438.52 Choice All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP covering a specific catchment area. The state requests authority to waive 438.52. This section will not be waived for BHSO regions.

For BHSO in FIMC regions:

Competitive procurement is limited to existing Apple Health MCOs. Procurement activities include both internal and external review. Development activities consist of 1) contract language, 2) RFP questions and scoring, 3) legal review, 4) incorporation of internal and external comments, 5) draft rates, 5) minimum qualifications, and 6) RFP timeline.

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

IBHP

BHSO

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

- a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
 - The PIHP is paid on a risk basis**
 - The PIHP is paid on a non-risk basis**
- c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
 - The PAHP is paid on a risk basis**
 - The PAHP is paid on a non-risk basis**
- d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.
 - the same as stipulated in the state plan**
 - different than stipulated in the state plan**
 - Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

Procurement for MCO

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PIHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

In accordance with State law, the State has used a non-competitive procurement process for the BHOs. The State is in agreement with CMS that the BHOs have the first opportunity to contract to operate the PIHP for outpatient behavioral health services (mental health and substance use disorder treatment), community mental health inpatient services, and residential substance use disorder services.

The State enters into a PIHP contract with the BHOs. If the BHO chooses not to participate, or is unable to meet required qualifications, DBHR will secure an alternate contractor. This would be facilitated as specified in Section A: Program Overview, 2. Sections Waived, e. Other Statutes and Relevant Regulations Waived. This information is also in the PIHP Contract. Measures are taken to avoid disruption of care for individuals.

Other risk contracts are those that have a scope of risk that is less than comprehensive. This PIHP is for behavioral health. The PIHP contractor is at-risk for:

Outpatient hospital services for community behavioral health (mental health and substance use disorder) rehabilitation services, including a subset of inpatient hospital services, for community mental health inpatient admissions and residential substance use disorder admissions.

For BHSO in FIMC region:

Competitive procurement is limited to existing Apple Health MCOs. Procurement activities include both internal and external review. Development activities consist of 1) contract language, 2) RFP questions and scoring, 3) legal review, 4) incorporation of internal and external comments, 5) draft rates, 5) minimum qualifications, and 6) RFP timeline.

Procurement for PAHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PCCM

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for FFS

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

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

The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

The State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to PIHP contracts and the mandatory enrollment process established for PIHPs.

The State mandates enrollment into a single PIHP for each geographic area in the BHO regions. In FIMC regions enrollees will have choice of PIHPs.

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

Program: " Integrated Behavioral Health Program. "

Two or more MCOs

Two or more primary care providers within one PCCM system.

A PCCM or one or more MCOs

Two or more PIHPs.

Two or more PAHPs.

Other:

please describe

Enrollees continue to have a choice of behavioral health (mental health and substance use disorder treatment) providers within their BHO/BHSO network.

Program: " Behavioral Health Services Only for Fully Integrated Managed Care Region. "

Two or more MCOs

Two or more primary care providers within one PCCM system.

A PCCM or one or more MCOs

Two or more PIHPs.

Two or more PAHPs.

Other:

please describe

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

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

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

Beneficiaries will be limited to a single provider in their service area

Please define service area.

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

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

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

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

- **Statewide** -- all counties, zip codes, or regions of the State
-- *Specify Program Instance(s) for Statewide*

IBHP

BHSO

- **Less than Statewide**
-- *Specify Program Instance(s) for Less than Statewide*

IBHP

BHSO

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Skagit, San Juan, Island, Snohomish, Whatcom	PIHP	Amerigroup, CHPW , Coordinated Care, Molina, UnitedHealthcare
Pierce	PIHP	Amerigroup, Coordinated Care, Molina, UnitedHealthcare
Thurston, Mason	PIHP	Thurston Mason Behavioral Health Organization
Clallam, Jefferson, Kitsap	PIHP	Salish Behavioral Health Organization
Chelan, Douglas, Grant, Okanagan	PIHP	Molina Healthcare of Washington, Coordinated Care of Washington, Amerigroup.
Clark, Skamania, Klickitat	PIHP	CHPW, and Molina Healthcare of Washington, Amerigroup
9 Counties in Eastern Washington, listed separately in "Additional Information"	PIHP	Amerigroup, CHPW , Coordinated Care, Molina
Cowlitz, Lewis, Grays Harbor, Pacific, Wahkiakum	PIHP	Great Rivers Behavioral Health Organization
King	PIHP	Amerigroup, CHPW , Coordinated Care, Molina, UnitedHealthcare
Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens	PIHP	Amerigroup, CHPW on, Molina

Section A: Program Description

Part I: Program Overview

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

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

Greater Columbia Behavioral Health Regional Support Network PIHP consists of 9 counties: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima.

Medicaid enrollees have their choice of network providers contracted by the PIHP (BHO/BHSO)

As the state continues to expand Fully Integrated Managed Care, other RSAs will become part of the integrated delivery system. Statewide integration is planned for 2020 as directed by RCW 71.24.850.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid

if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

Mandatory enrollment

Voluntary enrollment

Other (Please define):

Section 1902: All included populations have incorporated the Affordable Care Act Medicaid population. This includes the New Adult Group - non-pregnant individuals age 19 - 64 who are not eligible under any other category of eligibility.

Former Foster Care children are now eligible under this waiver until age 26. In BHO regions most Medicaid enrollees, regardless of eligibility category are mandatorily enrolled in the PIHP in their region. Starting January 1, 2019 foster care children will be enrolled in a single statewide MCO for both physical and behavioral health services.

For BHO Regions only:

Beginning in July of 2017, American Indian/Alaska Native (AI/AN) enrollees will be exempted from mandatory enrollment into the BHOs under the Waiver for mental health and substance use disorder services in all Regional Service Areas (RSAs). AI/AN Medicaid enrollees will have the choice to enroll in a BHO for behavioral health managed care or in the FFS Behavioral Health Program for behavioral health care fee-for-service. If no selection is made, the beneficiary will be enrolled in the FFS Behavioral Health Program. AI/AN enrollees will have the option to change their selection at any time, which will take effect for the next month in accordance with enrollment rules to be determined by HCA.

For BHSO in FIMC regions only the following enrollees are included:

- 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)) Full dual eligibles – those individuals entitled to all Medicare and Medicaid benefits will be mandatorily enrolled in the BHSO portion of the FIMC plan. This is similar to the way Washington currently provides mental health services through the Regional Support Networks for all Washington citizens, except HCA will offer a choice of PIHPs for Behavioral health services.
- 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.
- 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 managed care program, such as Medicare Part C or the Apple Health Foster Care Program.
- Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- Beginning on July 1, 2017, American Indian/Alaska Native Medicaid beneficiaries will be enrolled for physical and behavioral health services automatically into FFS unless they elect to enroll into fully integrated managed care. They will not have the option to opt in for the Behavioral Health Services Only (BHSO) managed care benefit.
- Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State.
- SCHIP Title XXI Children --Medicaid beneficiaries who receive services through the SCHIP program.
- Foster Care Children-- will be enrolled in the BHSO component of the single statewide integrated foster care contract and wraparound contract.

Access to Care Standards for Mental Health Services will be used as the guideline for determining level of service required. The standards, submitted to the SPA mailbox, reflect eligibility requirements for mental health treatment services provided through this waiver. Access to Care Standards effective October 1, 2017 will continue to be updated to reflect any changes in Diagnostic and Statistical Manual as needed. The October 1, 2017 ACS update attached to this amendment was necessary in order to update the ICD-10 CM code set changes effective 10/1/17.

The state is implementing a new delivery model for youth needing intensive services called Wraparound with Intensive Services (WISe). As it is implemented, a new tool, the Child and Adolescent Needs and Strengths (CANS)

will be used to assess the need for the level of care. Information about the CANS can be found at: <https://www.wa-bhas.org/Default.aspx?nav=LH>

The PIHPs are expected to meet the behavioral health needs of the individuals they serve. They are encouraged to provide innovative and flexible supports. Services are provided by a community behavioral health agency that is licensed and/or certified by the state. All clinical services are to be provided by or under the supervision of an appropriately licensed or certified health professional.

In addition to the definition of health care professional specified in former 42 CFR 438.2, DBHR expanded the definition to include Mental Health Professional, mental health specialists, and chemical dependency professionals as defined in the Washington State Medicaid State Plan. This allows the public behavioral health system to continue to have qualified staff perform authorization of behavioral health services, second opinion, grievance and appeal functions appropriate to their scope of practice and experience, and allows the effective use of mental health professionals and chemical dependency professionals.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

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

Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance --Medicaid beneficiaries who have other health insurance.

Reside in Nursing Facility or ICF/IID --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

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

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

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

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

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

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

Retroactive Eligibility Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

Individuals in the Medicare Savings program; Qualified Medicare Beneficiaries (QMBs), Qualified Disabled Working Individuals (QDWI), Special Low Income Medicare Beneficiary (SLMB), and, Qualified Individual 1 (QI1).

Individuals in a spenddown. Once the spenddown is met, the individual is covered under the waiver.

Individuals in the Limited Casualty - Medically Needy Program (LCP-MNP) receiving Hospice Services.

Individuals in the Alien Emergency Medical (AEM) program - Emergency and Related Services Only (ESRO).

Individuals who receive only Family Planning or Take Charge benefits/services.

Individuals residing in ICF/IID receive outpatient behavioral health services through fee-for-service. Crisis, evaluation and treatment and inpatient treatment are covered by the BHO/BHSO.

Beginning in July of 2017, American Indian/Alaska Native (AI/AN) enrollees will be exempted from mandatory enrollment into the BHOs under the Waiver for mental health and substance use disorder services in all Regional Service Areas (RSAs). AI/AN Medicaid enrollees will have the choice to enroll in a BHO for behavioral health managed care or in the FFS Behavioral Health Program for behavioral health care fee-for-service. If no selection is made, the beneficiary will be enrolled in the FFS Behavioral Health Program. AI/AN Medicaid enrollees will have the option to change their selection at any time, which will take effect for the next month in accordance with enrollment rules to be determined by HCA.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

Emergency Services Category General Comments (optional):

The PIHP does not cover medical emergency services. Medicaid enrollees have access to emergency services 24/7 independent of the Waiver: PIHPs are not funded to purchase emergency services such as ambulance, emergency department services, or out of network emergency services. The PIHPs are only contracted for outpatient behavioral health care services and inpatient psychiatric services, which include crisis services.

Behavioral health emergency services are provided 24/7 through crisis services. The response to the crisis is from qualified individuals, rather than recorded messages. The intent is to facilitate efficient and effective crisis diversion and resolution; to resolve crisis in the least restrictive manner possible; crisis respite; investigation and detention services; and evaluation and treatment services.

Inpatient services for enrollees admitted through the emergency room are covered and paid for if the designated professional person for the enrollee(s) county of residence has conducted a pre-admission certification and conditions of medical necessity are met.

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

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

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

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

Other (please explain):

Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

The PIHP does not cover family planning. Family planning is not a behavioral health service and is covered under HCAs FFS medical.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

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

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

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

FQHC Services Category General Comments (optional):

The Health Care Authority (HCA) pays the full encounter rate to the FQHC/RHC for the qualified behavioral health encounters, then recoups whatever the BHO paid to the FQHC for that encounter.

5. EPSDT Requirements.

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

EPSDT Requirements Category General Comments (optional):

On December 19, 2013, the State and the Plaintiffs in the EPSDT class action lawsuit, T.R. v. Teeter and Quigley, entered into a settlement agreement. The settlement agreement was filed with and approved by the U.S. District Court for the Western District of Washington. The agreement directs the State to develop a sustainable service delivery system for intensive services delivered in the home and community to Medicaid eligible children and youth, in substantial compliance with Title XIX of the Federal Social Security Act, and specifically the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of Medicaid. The objective is the development and successful implementation of a five-year plan that delivers medically necessary intensive services using a delivery model called Wraparound with Intensive Services (WISe).

PIHPs are required by contract to provide cross-system coordination for children, youth and the families who are receiving services through more than one child-serving services system. Coordination with other DSHS program areas is also expected as part of treatment planning. The team may include key providers, the child/youth and family, schools and natural supports.

Community mental health agencies coordinate with any systems or organizations the individual identifies as being relevant to the individual treatment, with their or their guardian consent. This includes coordination with the individualized family service plan (IFSP) when serving children three years of age or under.

Children/youth that do not have a primary care provider are provided information on how to obtain a provider from the PIHP, as required by PIHP contract.

Any child/youth being treated in the behavioral health system that is in need of other healthcare services, such as a well child checkup, dental services, or substance abuse counseling, are referred to the proper provider and/or the primary care provider.

The BHO is required to develop or update allied system coordination plans that include plans with community mental health clinic agencies, FQHCs, and Medicaid managed care organizations.

The PIHP Contract requires the PIHP to respond to EPSDT referrals from primary medical care providers with at least a written notice that must at a minimum include date of intake and diagnosis.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

This waiver includes no (b)(3) Services

7. Self-referrals.

The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the

MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Each BHO has a crisis system, which is accessible 24 hours/7 days a week with responses from individuals, rather than recorded messages. This crisis system includes the following: crisis intervention; crisis respite and evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.

The BHSO subcontracts with a Behavioral Health Administrative Services Organization for crisis services, which is accessible 24 hours/7 days a week with responses from individuals, rather than recorded messages. This crisis system includes the following: crisis intervention, crisis respite, and evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.

Crisis response services are provided in the following manner:

- * Toll free numbers that ensure access to crisis services. Access for non-English speaking and hearing impaired enrollees must also be in place.
- * Enrollees have unrestricted access to the crisis response system, without establishing medical necessity for the first contact, and without reference to the enrollee's ongoing service coverage under a particular PIHP.
- * Triage with local hospitals to reduce unnecessary utilization of the Emergency Department (ED) through working agreements with local evaluation and treatment facilities. ED visits not resulting in admission are not covered by this waiver, inpatient services for enrollees admitted through the ED are covered provided pre-admission certification and conditions of medical necessity are met. Crisis response services can also coordinate, refer and arrange for SUD services available within the PIHP, to address an enrollee's needs related to substance use abuse or dependence.
- * PIHPs must report crisis services provided to the HCA/CIS system. Crisis services are monitored by HCA as well as the PIHPs on an ongoing basis. Additionally, the transition from crisis services to routine services is monitored to ensure compliance with Access to Care Standards.

8. Other.

Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Hospitals

Please describe:

6. Mental Health

Please describe:

7. Pharmacies

Please describe:

8. Substance Abuse Treatment Providers

Please describe:

9. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Urgent care

Please describe:

8. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services.

Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

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

Please describe the enrollment limits and how each is determined:

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

Please describe the States standard:

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

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

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

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

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

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

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

- g. **Other capacity standards.**

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

- a. The plan is a PIHP/PAHP, and the State has determined that based on the plans 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:

In previous waiver periods, the State negotiated with CMS to define all Medicaid clients with serious mental illness or children with a serious emotional disturbance as special needs clients and to treat these clients accordingly when providing mental health services through the PIHP system.

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

Please describe:

Access to Care Standards (ACS) were effective October 1, 2017 and include Access to Care Standards for both MH and SUD. The ACS are used for serving special needs populations with serious and persistent mental illness and/or substance use disorders. A copy of the ACS was delivered to the SPA mailbox with the submission of this amendment.

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

Please describe the enrollment limits and how each is determined:

The State requires PIHPs and Apple Health Managed Care Organizations (MCOs) to work cooperatively to manage enrollee services from both systems in the most efficient and effective manner. The PIHPs and MCOs also coordinate to transition services for enrollees who have received the maximum mental health services under the benefit administered by the MCOs and are transitioning to the PIHP managed mental health system.

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

1. Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. In accord with any applicable State quality assurance and utilization review standards.

Please describe:

1. It should be noted that in the context of Managed Behavioral Health services, the Mental Health Professional and CD Professional acts as the PCP in developing a treatment plan. The treatment plan is developed collaboratively with the individual and other people identified by the individual as his or her support system. The treatment plan is developed within thirty days of starting community support services. The service plan is in language and terminology that is easily understood by the individual and his or her family, and includes goals that are measurable.
2. The PIHP must have a written policy and procedure to ensure consistent application of requests within the service area. The PIHP must monitor the use and pattern of extensions and apply corrective action where necessary. Urgent and emergent medically necessary behavioral health services (e.g. crisis behavioral health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.
3. HCA monitors the BHO/BHSO services consistent with CMS requirements.\

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

Please describe:

In addition to the definition specified in 42 CFR 438.2, the Medicaid State Plan expanded the definition of provider to include mental health professional, mental health specialists and chemical dependency professionals. This allows the public behavioral health system to have qualified staff perform authorizations for behavioral health services, second opinions, grievance and appeal functions appropriate to their scope of practice and experience; and, directly supports quality services for individuals.

PIHPs are required to note primary health care providers (PCPs) in individual files to refer an enrollee if needed. If the enrollee does not have a primary health care provider, they are given information to obtain a primary health care provider.

BHSO language directs the PIHP to allow individuals with special health care needs, whose treatment plan indicates the need for frequent utilization of a specialist, to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care.

Section A: Program Description

Part II: Access

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

- 3. Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services.

Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.
- b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.
- c. Each enrollee is receives **health education/promotion** information.

Please explain:

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. **Additional case management** is provided.

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

i. **Referrals.**

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

Section A: Program Description

Part II: Access

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

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

The BHOs (through contract requirements) and the Department of Health (through licensing) monitor that treatment plans that are developed with the participation of the individual and their natural support system. The licensing team looks for quotes attributable to both the individual and those whom they have identified as being an integral part of their treatment. State rules (Washington Administrative Code) require the plan to be written in language and terminology easily understood by the individual. When reviewing treatment plans, the team also looks for abbreviations, overly complicated clinical descriptions, etc. The team reviews for documentation of coordination of services and consultation with the appropriate clinical staff including children, geriatric, ethnic minority and disability mental health specialists when appropriate.

The Mental Health Statistics Improvement Program, Mental Health Consumer Survey,(MHSIP)monitors satisfaction with participation in treatment and treatment planning. The 2014 survey results have been sent to the SPA mailbox.

The current Fee for Service substance use disorder treatment delivery system the Statewide Patient Satisfaction Survey is used.

The MHSIP survey will be used for satisfaction for both Mental Health and SUD treatment and treatment planning. The state plans to continue to use this survey statewide including in BHSO regions.

The State requires the PIHP to coordinate health care services with other providers. This will continue to be monitored through the External Quality Review Organization (EQRO) protocols. For BHSO regions HCA used NCQA process and their own review teams. Example list of provider types included in coordination of services are:

- Local Health Departments
- Dental Providers
- Transportation Providers
- HCBS (1915(c)) Service
- Developmental Disabilities
- Title V Providers
- Medical Providers
- Indian Health Services (IHS) operated programs, 638 tribally operated programs and urban Indian health programs.
- For the BHSO, HCA has contract language that requires coordination of services through the Health Home Qualified Lead entities
- Other local service providers

PIHPs work in partnership with a variety of community agencies to coordinate care for enrollees. The PIHPs and Behavioral Health providers are required to participate in multi-system coordination efforts whenever possible. They are required to refer individuals to alternate or additional services that the individuals' or the Behavioral Health Provider believes is necessary to complete or aid in the recovery process.

PIHP contracts have the following coordination requirements:

-PIHPs must participate in the coordination of behavioral health services with other systems of care when clinically indicated; and must:

*Maintain HCA approved allied system coordination plans developed with DSHS Children's Administration and DSHS/ALTSA.

*Maintain the existing working Agreement with the DSHS Rehabilitation Administration (RA) addressing the coordination of services for enrollees that are released from JRA facilities.

*Maintain the relationship between the PIHP and Apple Health Plans in the contracted service area(s) through a Memorandum of Understanding.

*Maintain relationships between the PIHP and the Department of Corrections (DOC) office and DSHS Division of Vocational Rehabilitation (DVR) office in the service area.

*Comply with published directives from DBHR or HCA when the PIHP or its subcontractors are unable to resolve local disputes with other service systems (e.g. Apple Health; other DSHS or HCA administrations) regarding service or cost

responsibilities.

*PIHPs are required to collaborate with tribal mental health providers to ensure coordination of services as well as appropriate placement of tribal individuals into inpatient treatment, as necessary. PIHPs also coordinate with tribal behavioral health systems to ensure appropriate discharge planning from inpatient treatment facilities; and, are required to provide crisis services. In addition, the PIHP contracts can be updated as a result of agreements made through formal Consultation with the tribes.

During the tribal consultations on June 3, 2016 and June 22, 2016 DSHS and HCA affirmed the State's commitment to the development of a tribal centric behavioral health system that improves access, better serves the needs, and respects the individual Indian healthcare providers and their bona fide criteria and policies, of tribes and their members. Through joint monthly meetings with the parties identified on page 10 in Section 1.4 of the State Plan (TN#11-25) work has been done to identify issues and needs along with proposed solutions and analysis of how to achieve the proposed solutions. These issues have been collected and placed in an issues grid, which is reviewed at the monthly meetings. Many of the items identified will help to inform the work that will take place to achieve the full carve out for July 1, 2017. HCA will continue to follow the consultation with the tribes process (and meet and confer process with the Indian Health Service and urban Indian health organizations) to identify and address mitigation strategies for the interim, where possible. This planning has all been done with the mutual understanding that some proposed solutions may require additional federal or state statutory changes.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

Section 1902(a)(4) is waived to permit the State to mandate beneficiaries into a single PIHP and restrict disenrollment.

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

approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

06/01/07 (mm/dd/yy)

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

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

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	QUALIS	2014-2017	See comments	EDV

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

--

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

Please check any processes or procedures listed below that the State uses in the process of selecting and

retaining PCCMs. The State (please check all that apply):

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. Initial credentialing
 - B. Performance measures, including those obtained through the following (check all that apply):
 - The utilization management system.
 - The complaint and appeals system.
 - Enrollee surveys.
 - Other.

Please describe:

4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

For BHO regions QUALIS Health is now the contracted EQRO. This contract began with the RSNs on 1-1-15 and will be referred to as "contracted EQRO". The contracted EQRO annually conducts external quality reviews of the outcomes, timeliness, and access to services delivered under the PIHP contract. The contracted EQRO has a three year plan:

Year One: Compliance: Enrollee Rights and Grievance Appeal, PIP, PM; ISCA

Year Two: Compliance: QAPI and Program Integrity (follow up on prior year), PIP (follow up on prior year) PM: ISCA (follow up only)

and Encounter Data Validation (EDV)

Year Three: Compliance: follow up only on PIP, PM: ISCA, Quality Strategy

Individual contractor reports from the EQRO are submitted to the State every year in addition to the joint annual report (HCA/DBHR). The annual report is submitted to CMS yearly. The 2015 Quality report has been sent to CMS via the SPA mailbox.

DBHR in partnership with HCA are working on a joint draft Quality Strategy for CMS to review in 2016. Any recommended changes to the draft will be incorporated once they are received from CMS.

For the BHSO, a competitive procurement will be done to select the PIHPs within each regional service area. No less than two PIHPs will be selected through the procedure process. For the first regional service area, the evaluation process included 47 questions with the following weights: Management and Technical Proposal – 600 points, Network Adequacy Submission – 200 points, Business References – 30 points. Within the Management and Technical Proposal, HCA weighted the Quality Assessment and Performance Improvement questions with 40 points. HCA expects future competitive procurement selections will be done in a similar fashion, though questions and weighting may change based upon BHSO experience.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

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

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

Because of mandatory enrollment into the BHO in a Medicaid enrollees service area, there is no "marketing", as there is no choice of a different PIHP. The state provides the Behavioral Health Benefits Book to all Medicaid enrollees through the BHOs and upon request and the BHOs may or may not have additional information about their own services, but no marketing.

HCA automatically sends a BH Benefits Book to all new enrollees in the BHSO and requires the BHSO to send a plan specific BH handbook to all enrollees using a template pre-approved by HCA.

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

For BHSO in and the FIMC region only the State permits PIHPs to produce informational materials, including disease management and health promotion materials, social media, and radio and TV spots as approved by the State. All materials produced by PIHPs and distributed to their enrollees or potential enrollees are reviewed and approved by the State prior to distribution. The State may allow PIHP participation in community events, including health fairs, educational events, and booths at other community events.

The State does not allow direct or indirect door-to-door, telephonic, or other cold call marketing of enrollment.

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

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

1. The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

There are no potential enrollees. All Medicaid enrollees included in this waiver and are enrolled into a PIHP in their service region.

2. The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

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

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

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

Please describe the methodology for determining prevalent languages:

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

- c. Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

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

There is no marketing allowed. The state provides information to all enrollees through the mental health benefits booklet or through other methods upon initial enrollment and yearly notification of rights.

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

Because of mandatory enrollment, there are no "potential" enrollees. Materials produced for enrollees are translated into 12 languages; plans produce materials in languages spoken by 5% or more of their enrollees. The 12 languages translated by the State are: Spanish, Russian, Vietnamese, Korean, Cambodian, Laotian, Somali, Chinese, Amharic, Arabic, Punjabi and Ukrainian

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

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

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

Please explain how the State defines significant.:

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

- c.** Other

Please explain:

The state defines "significant" population as 5% of the enrollee population. Some BHOs will use this standard, however the state translates into eight languages.

The BHSO contract language defines "significant" population as 5% of the enrollee population. All BHSO PIHPs use this standard. Additionally, HCA translates BHSO enrollee material into all 12 languages.

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

The PIHP requires language or format as preferred by the enrollee. If oral translation services are requested, the BHOs/Community Behavioral Health agencies provide an interpreter for this purpose at any/all appointments or as requested.

In the BHSO, providers are responsible for interpreter services when an enrollee is accessing BH services.

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

Please describe:

Enrollees receive an explanation of behavioral health managed care benefits by letter with their assignment letter or the ACES renewal letter. The BH benefits booklet is also offered at every intake and available online.

For the BHSO: A Welcome to Washington Apple Health book is sent to all newly eligible enrollees with their assignment letter. The letter gives information about the PIHP.

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

State

Contractor

Please specify:

The State provides the Behavioral Health Benefits Book and keeps it updated online. The State also provides behavioral health managed care information to Medicaid Enrollees upon initial approval and an annual reminder of Rights. The Contractor is required to post Rights, offer the benefits booklet at every intake, and provide other information upon Enrollee request.

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

the State

State contractor

Please specify:

The State publishes the benefits booklet and keeps it current online. The State has also ensured Medicaid enrollees receive information upon initial eligibility determination, and notice of rights every year at eligibility review. The BHOs are responsible for ensuring a benefits booklet is offered at every intake, rights are posted, and other information as requested is available.

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

Section A: Program Description

Part IV: Program Operations

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

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

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

For BHO Regions:

There is no disenrollment or freedom of choice of PIHPs as all Medicaid enrollees are mandatorily enrolled into the PIHP in their service area for behavioral health care services. An enrollee does have a choice between providers within their service area.

For BHSO Regions:

The enrollee has a choice between PIHPs.

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

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

a. Outreach

The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

State staff conducts the enrollment process.

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

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

Broker name:

Please list the functions that the contractor will perform:

choice counseling

enrollment

other

Please describe:

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

This is a **new** program.

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

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

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

The BHSO will be phased in gradually in RSAs starting on April 1, 2016 in Clark and Skamania Counties and ending in 2020 when implementation is complete and all RSA will be operated under the FIMC contracts and processes. On January 1, 2019, four additional regions joined the FIMC model, and another will join on July 1, 2019, leaving just three BHO regions. These remaining three regions will transfer to the FIMC model by the latest on January 1, 2020.

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

- i. Potential enrollees will have **day(s) / month(s)** to choose a plan.
- ii. There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

The State automatically enrolls beneficiaries.

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

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

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

Please specify geographic areas where this occurs:

For BHSO regions only an individual will have a choice of PIHP. If they do not choose one they will be reconnected to a plan based upon family connects and plan reconnects. The enrollee has the right to change PIHPs at any time.

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

The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

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

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

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

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

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

The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.
Please describe the reasons for which enrollees can request reassignment

For BHSO in FIMC region: The enrollee purposely puts the safety or property of the PIHP, or the PIHP's staff, providers, patients, or visitors at risk; or

The enrollee engages in intentional misconduct, including refusing to provide information to the Contractor about TPL.

The enrollee must receive written notice from the PIHP requesting the enrollee's enrollment termination, unless the state waives the requirement for notification because the enrollee's conduct threatens imminent harm to others. The PIHP's enrollee notice shall include the enrollee's right to use the PIHP's grievance process to review the request to end the enrollment.

HCA will not terminate enrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of the enrollee's health care, because of the enrollee's medical utilization, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 CFR 438.56(b)(2))."

If termination of enrollment is accepted, the enrollee will be placed with another PIHP for BHSO services.

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

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

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

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

The State has waived disenrollment rights.

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

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

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

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

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

b. Timeframes

The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is

days (between 20 and 90).

The States timeframe within which an enrollee must file a **grievance** is days.

c. Special Needs

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

Please describe:

All enrollees covered under this waiver are considered special needs. Ombuds are available to assist all enrollees receiving care under the PIHP behavioral health system for both mental health substance use disorder.

There is no limit on the timeframe in which an enrollee must file a grievance.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

the State

the States contractor.

Please identify:

the PCCM

the PAHP

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

Please describe:

Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

Specifies a time frame from the date of action for the enrollee to file a request for review.

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

Has time frames for resolving requests for review.

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

Establishes and maintains an expedited review process.

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

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

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

Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

The State has no "timeframe within which an enrollee must file a grievance." There are other timeframes in the grievance process that must be met:

- An enrollee may file a grievance in person, with a telephone call or in writing.
- The provider or BHO must tell the enrollee by telephone or send a letter to the enrollee within five calendar days as notification of receipt of the request for a grievance. If the enrollee is informed by telephone, the provider or BHO must also send a letter within five working days.
- There are timelines that must be followed by the provider and the BHO. Within 90 days from the time an enrollee makes the initial request the enrollee will receive a decision letter. An enrollee may ask for an additional 14 calendar days for the BHO to respond, or the BHO may ask for an additional 14 days to make a decision if more information is needed. The request for more time must be in the enrollee's best interest. The request for the additional time must state the reason for the request.
- The enrollee will receive a letter from the PIHP with the decision about the grievance prior to the expiration of the additional requested time, or 90 days from the initial request if no additional time is requested.
- If an enrollee does not receive a letter within the timeframes in the rules, or the enrollee disagrees with the PIHP decision, a request for an administrative (fair) hearing may be requested.

For the BHSO, enrollees must grieve at the PIHP level. If the denial is upheld, the enrollee may appeal through the HCA Fair Hearing process.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs 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 MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

--

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

approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Each PIHP is paid on a Per Member Per Month (PMPM) schedule for Medicaid Enrollees in their service area. Encounter Data is submitted from the PIHPs and is certified and validated both internally and by the contracted EQRO for BHO regions and HCA internally for BHSO regions.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

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

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Data Analysis (non-claims)	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Enrollee Hotlines	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Focused Studies	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Geographic mapping	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Independent Assessment	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Measure any Disparities by Racial or Ethnic Groups	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Network Adequacy Assurance by Plan	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Ombudsman	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	FFS	FFS	FFS	FFS	FFS	FFS
On-Site Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Performance Improvement Projects	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Performance Measures	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Periodic Comparison of # of Providers	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Profile Utilization by Provider Caseload	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Provider Self-Report Data	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Other	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Accreditation for Participation	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Consumer Self-Report data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	FFS	FFS	FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Other	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Accreditation for Participation	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Consumer Self-Report data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	FFS	FFS	FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PCCM FFS	PCCM FFS	PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
IBHP	PIHP;
BHSO	PIHP;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Integrated Behavioral Health Program

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

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

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a.

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

Activity Details:

NCQA

JCAHO

AAAH

Other

Please describe:

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

Activity Details:

NCQA

JCAHO

AAAHC

Other

Please describe:

- c. **Consumer Self-Report data**

Activity Details:

Annual Enrollee Satisfaction Survey Information as well as Grievance, Appeals, and Fair Hearings reports are utilized as consumer self-report data. This information is collected by DBHR staff and utilized to improve services in identified areas. The MHSIP survey monitors satisfaction with participation in treatment and treatment planning. The survey results are at: website

Grievance/Appeals/Fair Hearings

- Personnel responsible

HCA staff

- Detailed description of activity

PIHPs are required to submit detailed Grievance/Appeals/Fair Hearings deliverables that including, aggregate data elements, narrative analysis, trends and how this information is used quality improvement processes.

- Frequency of use

Quarterly

- How it yields information about the area(s) being monitored

HCA staff review the reports to identify trends or concerns in each PIHP region, and state-wide. HCA staff meets with the PIHP Quality Management Leads every other month to address any identified trends and to provide ongoing technical assistance.

CAHPS

Please identify which one(s):

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d.

Data Analysis (non-claims)

Activity Details:

EQRO monitors Encounter Data Validation (EDV)

Grievance, Appeals, and Fair Hearing Data is also monitored by DSHS for their respective regions as indicators of potential issues that need to be addressed more formally.

Encounter Data Validation (EDV)

Personnel responsible Qualis Health (EQRO)

- Detailed description of activity

Qualis Health's EDV process consists of electronic data checks – state-level validation of all encounter data received by the State from the PIHP during the review period; and a clinical record review – independent validation of state encounter data matched against provider-level clinical record documentation to confirm the findings of the PIHP's internal EDV.

- Frequency of use

Annually for each PIHP.

- How it yields information about the area(s) being monitored

HCA analyzes the information received from Qualis Health to assess the data integrity of the PIHP. This allows HCA to determine whether data integrity issues are isolated or prevalent, and whether a state-wide intervention is needed.

Grievance/Appeals/Fair Hearings

- Personnel responsible

HCA staff

- Detailed description of activity

PIHPs are required to submit detailed Grievance/Appeals/Fair Hearings deliverables that report aggregate data elements at the provider and PIHP levels. Reports also include a narrative analysis, documenting any overall trends and how these trends are utilized in their ongoing quality management/improvement processes.

- Frequency of use

Quarterly

- How it yields information about the area(s) being monitored

HCA staff review the reports to identify trends or concerns in each PIHP region, and state-wide. HCA staff meets with the PIHP Quality Management Leads every other month to address any identified trends and to provide ongoing technical assistance. The Grievance Committee also informs the HCA Quality Improvement Committee of systemic issues or concerns.

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

e.

Enrollee Hotlines

Activity Details:

f.

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

Activity Details:

There are two categories of focused studies for 2017/18: Follow up studies on 2016/17 projects and new projects for 2017/18.

Follow-Up On 2016/17 Studies

In 2017, the state will continue to follow up on these studies, as outlined below:

1. Children's Mental Health system redesign (2016, follow-up in 2017)
 - Personnel responsible: Qualis Health (EQRO)
 - Detailed description of activity: Program compliance review and EDV of Wraparound with Intensive Services (WISe).
 - Frequency of use: This focus study was completed in 2016, but Qualis Health will review each PIHP again in 2017 to determine whether any identified deficiencies were addressed.
 - How it yields information about the area(s) being monitored: This focused study results in a thorough reporting of whether WISe services are being provided in accordance with the WISe program model and that encounters are being coded and submitted correctly.
2. The transition of RSNs to BHOs as set forth in RCW 71.24. (2016, follow-up in 2017)
 - Personnel responsible: Qualis Health (EQRO)
 - Detailed description of activity: Qualis Health reviewed and evaluated each PIHP's status in meeting the timeframes established in its transition plan for converting from a Regional Support Network (RSN) to a Behavioral Health Organization (BHO) and integrating substance use disorder (SUD) treatment providers into the behavioral health network. This also included site visits to two SUD providers per BHO.
 - Frequency of use: This focus study was completed in 2016, but Qualis Health will review each PIHP again in 2017 to determine whether any identified deficiencies were addressed.
 - How it yields information about the area(s) being monitored: This focused study results in a thorough reporting of each PIHP's transition to ensure that the integration of SUD services into managed care is operating effectively and according to contract.

Additional Study for 2017/18

Focus on "Golden Thread" in Documentation

- Personnel responsible: Qualis Health
- Detailed description of activity: Qualis Health, as part of the 2017/18 Encounter Data Validation process will include a review of the "golden thread". The golden thread concept requires providers to accurately assess individuals and have up to date treatment planning and ensure that any treatment provided is tied to the treatment plan, as evidenced by the provider's chart notes.
- Frequency of use: This study will begin in 2017 and is expected to continue into 2018.
- How it yields information about the area(s) being monitored: The study will determine whether BHOs are ensuring that providers are meeting clinical and documentation requirements.

g.

Geographic mapping

Activity Details:

h.

Independent Assessment (Required for first two waiver periods)

Activity Details:

i.

Measure any Disparities by Racial or Ethnic Groups

Activity Details:

j.

Network Adequacy Assurance by Plan [Required for MCO/PIHP/PAHP]

Activity Details:

HCA Contract Monitoring Staff and the state contracted EQRO ensure provider adequacy through yearly on-site visits, ratio of population in service area, and availability of providers within the PIHP service area to assist non-English speaking residents. RD Q M 1

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)

HCA Contract Monitoring Staff and Qualis Health (EQRO)

- Detailed description of activity

Qualis Health looks at a number of different criteria, including the PIHPs' geo-mapping, the ratio of providers in the service area/ratio of population in the service area and availability of specialists, the number of non-English speaking residents, interpreter services and requests for translation services logs, grievances regarding availability of services, survey results, and timeframes for intakes and follow-up appointments. Qualis Health also interviews providers regarding service needs.

DBHR Contract Monitoring Staff reviews PIHP subcontractor lists for each service type to ensure that each service type is covered, the PIHP's geo-mapping, and grievance trends regarding access.

- Frequency of use

Annually for each PIHP.

- How it yields information about the area(s) being monitored

Information received helps HCA to determine whether regulatory and contractual standards governing managed care were met.

k.

Ombudsman

Activity Details:

I. On-Site Review

Activity Details:

State licensing/contract monitoring staff and the contracted EQRO complete on-site reviews yearly to ensure contracts, client’s rights, licensing and certification issues, and 42 CFR 438 requirements are met by each PIHP and their subcontractors.

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

Activity Details:

QUALIS Health, Inc. (EQRO Contractor/Q.I.O.)

The EQRO monitors for all 42 CFR 438 activities using the CMS protocol. Compliance with Performance Measures and PIPs (clinical and non-clinical) are completed yearly. Compliance with QAPI and Program Integrity are completed every three years.

Encounter Data Validation (EDV) is completed every other year, and the Quality Strategy, being developed by HCA will be reviewed annually.

Individual PIHP reports are submitted to the State every year as well as a State-wide report. The State-wide report is submitted to CMS yearly in December to January.

☐ Clinical

☐ Non-clinical

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor

Qualis Health (EQRO)

- Detailed description of activity

By contract, each PIHP is required to have 3 PIPs, including a clinical and non-clinical PIP. Of the 3 PIPs, one also must be a Children’s PIP, and one must be an SUD PIP. Qualis Health evaluates the PIPs to determine whether they are designed, conducted, and reported in a methodologically sound manner. The PIPs must be designed to achieve, through ongoing measurements and intervention in clinical and non-clinical areas, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction.

- Frequency of use

Annually for each PIHP

- How it yields information about the area(s) being monitored

Qualis Health assigns a score of “Met”, “Partially Met”, or “Not Met” to each of the 10 evaluation components that are applicable to the PIP being evaluated. State staff use this information to create plans of correction if needed in order to move the BHO towards fully met.

Clinical

Non-clinical

n. Performance Measures [Required for MCO/PIHP]

Activity Details:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs collect and track performance measure data and submit this information to HCA and the State's EQRO.
- Detailed description of activity: The EQRO analyzes the data to track trends and potential improvements in outcomes and produces a yearly EQR Report. The State uses that information to provide evidence of how external quality review findings, State audits and Contract monitoring activities are used to identify and correct problems to improve care and services to enrollees.
- Frequency of use: An analysis of the performance measures will be done in 2017 to allow a full year's worth of data to be collected. Beginning in 2018, data will be used annually.
- How it yields information about the area(s) being monitored: HCA will analyze the data

annually for a period of 3 – 5 years to observe/assess performance over time. By analyzing the data annually over a period of years, the State will see trends emerging related to how well the PIHPs are meeting the needs of enrollees with mental health and substance use disorder, including referrals and treatment completion.

Based on PIHP performance, HCA may amend the contract to require that the PIHP:

- Add contract elements that require the PIHPs to reach out to these clients to ensure they are getting appropriate care or
- Incorporate performance on these measures in value-based purchasing approaches.

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

0.

Periodic Comparison of # of Providers

Activity Details:

QUALIS Health the EQRO and contract monitoring staff ensure that the population in the PIHP service area is served adequately by the number of providers subcontracted through the PIHPs Community Behavioral Health Agencies.

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor

DBHR contract monitoring staff and Qualis Health (EQRO)

- Detailed description of activity

Qualis Health assesses and evaluates the provider network agencies the criteria outlined in § 438.206(b)(1): Availability of Services – Delivery Network, and reviewing grievances and state fair hearings for dissatisfaction related to access and availability of services. Qualis Health also analyzes data for under and overutilization of services to ensure that enrollees are receiving appropriate number of services.

- Frequency of use

Annually.

- How it yields information about the area(s) being monitored

Qualis Health reviews and analyses information collected from quality and utilization plans, data collected through clinical record reviews, and data obtained from onsite and telephonic interviews with both PIHPs and providers.

p.

Profile Utilization by Provider Caseload (looking for outliers)

Activity Details:

q.

Provider Self-Report Data

Activity Details:

Survey of providers

Focus groups

r.

Test 24/7 PCP Availability

Activity Details:

s.

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

Activity Details:

t.

Other

Activity Details:

Fiscal Monitoring of PIHPs (Sub Recipient) is done annually for the 9 BHO's in the State.

Fiscal Monitoring activities include:

- Verification of amount reported on Revenue and Expenditures (i.e., DBHR internal management accounting report) report is accurate, supported by documentation and properly allocated.
- Compliance to 2CFR 200 for PIHP Subcontractors when applicable.
- Assessment of the reliability of internal control.

Fiscal Monitoring of PIHPs

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor

DBHR fiscal monitors

- Detailed description of activity

The DBHR fiscal monitor conducts a review of each PIHP's internal controls and cost allocation plan and supporting documentation, verifies the amounts reported on their revenue and expenditures reports, and reviews reserve and fund balance accounting and reserve amounts for encumbrances. In addition, the PIHP's subcontractor's contracts, payments, and reconciliations are reviewed.

- Frequency of use

Annually for each PIHP.

- How it yields information about the area(s) being monitored

The review and verification of the above documents ensures that the PIHP is in fiscal compliance with applicable state and federal requirements and contract.

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Behavioral Health Services Only for Fully Integrated Managed Care Region

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

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

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a.

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

Activity Details:

NCQA

JCAHO

AAAHHC

Other

Please describe:

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

Activity Details:

Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor) - The MCO is responsible for obtaining NCQA certification.

Detailed description of activity – The State requires NCQA certification to participate in the State’s managed care program. Compliance is validated by the state and NCQA.

Frequency of use – In accordance with NCQA guidelines, and as needed in quality and monitoring activities.

How it yields information about the area(s) being monitored - NCQA reviews and produces a report of the MCO’s compliance with NCQA standards.

NCQA

JCAHO

AAAHHC

Other

Please describe:

- c. **Consumer Self-Report data**

Activity Details:

CAHPS

Please identify which one(s):

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

- d. **Data Analysis (non-claims)**

Activity Details:

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

e.

Enrollee Hotlines

Activity Details:

f.

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

Activity Details:

g.

Geographic mapping

Activity Details:

Geographic mapping of provider network

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): HCA is responsible for this task.
- Detailed description of activity: The PIHPs are required to submit quarterly network adequacy reports. Additionally, PIHPs are required to submit network adequacy data when:

The Health Care Authority deems it necessary to request a network submission from the PIHPs based on credible information received from a provider or other stakeholder.

A PIHP has lost a material provider which might impact its ability to meet access standards or reduce provider choice in a service area.

HCA's Network Administrator evaluates submissions using GeoCoding software to ensure adequate network capacity exists in all areas for all contracted PIHPs.

For the integration of mental health and substance use disorder treatment providers, the Network Administrator has developed new Geocoding which will be tested during the Early Adopter Request for Proposals process as part of the analysis of the Behavioral Health network. Further refinements for BH submissions will be developed to increase analytic capabilities.

Anomalies may be identified during the quarterly review of network submissions. HCA also receives notification from provider groups and other stakeholders regarding potential changes to a PIHP's network. The Network Administrator follows up on all provider notifications on network. If a problem is identified, the Network Administrator will notify the PIHP of the deficiency and ask for a corrective action plan.

The corrective action depends on the issue(s) found. The Network Administrator works with network development staff at all of the PIHPs to develop relationships, answer questions and provide technical assistance in submitting accurate and adequate network submissions.

Corrective action may include the resubmission of the network with an accurate description of the contracted providers.

- Frequency of use: Geographic mapping will be done in 2017 and quarterly thereafter.
- How it yields information about the area(s) being monitored: The analysis provides information about the location, number and type of mental health providers by geographic location. This information is compared to the location of potential enrollees in the same geographic area to determine if the provider network is adequate to meet the needs of the population and meets the standard of 1 provider within 25 miles for urban/non-urban areas. A baseline will need to be established for substance use disorder treatment providers after the first year of the program in order to adequately understand the distribution of SUD providers within the RSA.

h.

Independent Assessment (Required for first two waiver periods)

Activity Details:

--

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

Activity Details:

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

Activity Details:

k. **Ombudsman**

Activity Details:

l. **On-Site Review**

Activity Details:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): HCA
- Detailed description of activity: HCA conducts a desk review of materials and enrollee files for each of the PIHPs for the waiver population. As part of the onsite visit, HCA reviews 10 each of the following files specific to the waiver population: Grievances, Appeals, Actions and Care Coordination for the waiver population.
- Frequency of use: On-site contract compliance reviews will start in 2017 and continue annually.
- How it yields information about the area(s) being monitored: Upon completion of the file review, each PIHP will receive performance feedback and Technical Assistance related to the findings of the file review. PIHP must submit corrective action plan (CAP) addressing deficiencies noted by the State. If the findings are severe or significant (Not Met), the CAP may be revisited during the year. The CAP is reviewed again at the following year's onsite visit, to ensure improvement in the area of deficiency.

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

Activity Details:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): HCA
- Detailed description of activity: During annual contract monitoring, the state reviews Performance Improvement Projects which are scored (Met, Partially Met, and Not Met) based upon the PIP. HCA looks at the following areas:

Defined study question Study indicators Sampling techniques
Data collection methodology Source of data
Data analysis plan
Qualitative and quantitative results and analysis Interventions

- Frequency of use: An analysis of the PIPs will be done in 2017 to allow a full year's worth of data to be collected. Beginning in 2018, data will be used annually.
- How it yields information about the area(s) being monitored: Results are trended to see if improvements (through ongoing measurement and intervention) show significant improvement, sustained over time, that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

Clinical

Non-clinical

n.

Performance Measures [Required for MCO/PIHP]

Activity Details:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor): PIHPs collect and track performance measure data and submit this information to HCA and the State's EQRO.
- Detailed description of activity: The EQRO analyzes the data to track trends and potential improvements in outcomes and produces a yearly EQR Report. The State uses that information to provide evidence of how external quality review findings, State audits and Contract monitoring activities are used to identify and correct problems to improve care and services to enrollees.
- Frequency of use: An analysis of the performance measures will be done in 2017 to allow a full year's worth of data to be collected. Beginning in 2018, data will be used annually.
- How it yields information about the area(s) being monitored: HCA will analyze the data

annually for a period of 3 – 5 years to observe/assess performance over time. By analyzing the data annually over a period of years, the State will see trends emerging related to how well the PIHPs are meeting the needs of enrollees with mental health and substance use disorder, including referrals and treatment completion.

Based on PIHP performance, HCA may amend the contract to require that the PIHP:

- Add contract elements that require the PIHPs to reach out to these clients to ensure they are getting appropriate care or
- Incorporate performance on these measures in value-based purchasing approaches.

Process

Health status/ outcomes

Access/ availability of care

Use of services/ utilization

Health plan stability/ financial/ cost of care

Health plan/ provider characteristics

Beneficiary characteristics

o. Periodic Comparison of # of Providers

Activity Details:

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

Activity Details:

q. Provider Self-Report Data

Activity Details:

Survey of providers

Focus groups

r.

Test 24/7 PCP Availability

Activity Details:

s.

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

Activity Details:

t.

Other

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

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

The State has used this format previouslyThe State provides below the results of the monitoring activities conducted during the previous waiver period.

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.

The Monitoring Activities were conducted as described:

Yes No

If No, please explain:

Both the BHO and the BHSO programs were only in place from April 2016 to December 2016 and monitoring results are not yet available.

Provide the results of the monitoring activities:

The following monitoring activities for the currently in place Waiver that will expire on 12-31-16 will be submitted as a separate document to CMS. Monitoring activities reported are limited in scope to monitoring of the Regional Support Networks (RSN), mental health only program.

Regional Support Network Activities Completed under Waiver expiring December 2016:

Item c. (Consumer Self-Report data)

Item d. (Data Analysis)

Item e. (Enrollee Hotlines)

item f. (Focused Studies)

Item j. (Network Adequacy Assurance Plan)

Item k. (Ombudsman)

Item l. (On Site Review)

Please see attached document for Section C: Monitoring Results For the RSN only Regions (pp. 67-71)

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Behavioral Health - Disabled Population (Data on Attached Spreadsheet Due to Waiver App Errors)	
BHSO - Disabled Population (Data on Attached Spreadsheet Due to Waiver App Errors)	
Behavioral Health - Non-Disabled Population (Data on Attached Spreadsheet Due to Waiver App Errors)	
Behavioral Health - Newly Eligible (Data on Attached Spreadsheet Due to Waiver App Errors)	
BHSO - Non-Disabled Population (Data on Attached Spreadsheet Due to Waiver App Errors)	
BHSO - Newly Eligible (Data on Attached Spreadsheet Due to Waiver App Errors)	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2014	09/30/2015	10/01/2015	09/30/2016
**Include actual data and dates used in conversion - no estimates				
*Projections start on Quarter and include data for requested waiver period				

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Enrollment Projections for the Time Period*	07/01/2017	06/30/2018	07/01/2018	06/30/2019
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

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

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Inpatient Hospital				
Outpatient Hospital Services (other than Lab & X-ray)				
Rural Health Clinic Services (Contracting Facilities Only included in 1915(b) Waiver Cost				
Federally Qualified Health Center Services (Contracting Facilities Only in 1915(b) Waiver Cost)				
Prof. & Clinic and other Lab and X-ray (ITA only included in 1915(b) Waiver Costs)				
EPSDT, including Chiropractic (only mental health component included in 1915(b) Waiver)				
Physicians' Services (Psychiatrist)				
Practitioners' Services, Other (Psychologists)				
Prescribed Drugs (Pharmacy)				
Chemical Dependency Service: Department Approved Alcohol/Drug Residential Treatment Centers				
Chemical Dependency Service: Detoxification				
Chemical Dependency Service: Opiate Substitution Treatment				
Chemical Dependency Service: Outpatient				
Mental Health Service - Brief Intervention Treatment				
Mental Health Service - Crisis Services				
Mental Health Service - Day Support				
Mental Health - Family Treatment				

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Mental Health Service - Freestanding Evaluation and Treatment				
Mental Health Service - Group Treatment Services				
Mental Health Service - High Intensity Treatment				
Mental Health Service - Intake Evaluation				
Mental Health Service - Medication Management				
Mental Health Service - Medication Monitoring				
Mental Health Services provided in Residential Settings				
Mental Health Service - Peer Support				
Mental Health Service - Psychological Assessment				
Mental Health Service - Rehabilitation Case Management				
Mental Health Service - Special Population Evaluation				
Mental Health Service - Stabilization Services				
Mental Health Service - Therapeutic Psychoeducation				
Behavioral Rehabilitation Services				
IMD Services for Age 65 and Older				
Inpatient Psychiatric Services (Under 21 Year of Age)				
Psychologist (Service may be FFS or through Inpatient Hospital)				
Inpatient Hospital				
Other Lab & X-ray Services				
Medical & Surgical Services Performed by a Dentist				
Podiatrists' Services				
Vision Care Services and Eyeglasses				
Licensed Midwives and Nurse Midwives				
Home Health Care Services				
Private Duty Nursing Services				
Clinic Services - Freestanding Kidney Centers Chronic Dialysis Centers				
Dental Services				

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Dentures				
Durable Medical Equipment Includes Prosthetic Devices, Excludes Hearing Aids				
Hearing Aids				
Preventive Services				
Rehabilitation Treatment Services				
Nurse Midwife				
Education Agency Services (School-Based Services for Special Family Preservation Services)				
Family Preservation Services				
Freestanding Birth Centers				
Intermediate Care Facility Services (other than an IMD)				
Intermediate Care Facility Services (in an IMD)				
Developmental Disabilities Services (part of ICF/MR) Developmental Hospice				
Targeted Case Management Services				
Extended Services for Pregnant Women				
Family Planning Services				
Obstetrical Services				
Respiratory Care				
Certified Pediatric or Family Nurse Practitioner Services				
Transportation				
Skilled Nursing Facility Services (Under 21 years of Age)				
Emergency Services (Outpatient Hospital Service)				
Personal Care				
PACE				

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States 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 States submitted CMS-64 forms.

Signature:

State Medicaid Director or Designee

Submission
Date:

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

b. Name of Medicaid Financial Officer making these assurances:

c. Telephone Number:

d. E-mail:

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

date of payment.

date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

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.*

- b. The State provides additional services under 1915(b)(3) authority.
- c. The State makes enhanced payments to contractors or providers.
- d. The State uses a sole-source procurement process to procure State Plan services under this waiver.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- a. MCO
- b. PIHP
- c. PAHP
- d. PCCM
- e. Other

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- a. Management fees are expected to be paid under this waiver.

The management fees were calculated as follows.

- 1. Year 1: \$ per member per month fee.
- 2. Year 2: \$ per member per month fee.
- 3. Year 3: \$ per member per month fee.

4. Year 4: \$ per member per month fee.

b. Enhanced fee for primary care services.

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

- c. Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. Other reimbursement method/amount.

\$

Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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

See below. Beginning January 1, 2014, the State expanded Medicaid under the Affordable Care Act. Note that the effective date for this Newly Eligible population occurs prior to the R1 data time period and as such, the data for this population is reflected in all time periods of the waiver spreadsheets.

Effective April 1, 2016 (beginning in the third quarter of R2 data and prior to P1), the State has redesigned the program in two key areas.

- The first is the transition of the current RSNs to Behavioral Health Organizations (BHOs) that will now provide Substance Use Disorder (SUD) services in addition to the currently managed Mental Health services.
- The second is the removal of the Clark and Skamania counties (Southwest BHO) from the behavioral health managed care program. These counties will shift to a fully integrated managed care (FIMC) program that includes both behavioral health and acute care services. Enrollment for the various MEGs is adjusted for the removal of these two counties.
- While the majority of the Clark and Skamania enrollees will be reported under a separate 1915(b) waiver or 1932a State Plan authority, certain enrollees will be eligible for behavioral health services only (BHSO). These BHSO individuals are included in this 1915(b) waiver amendment and will be grouped with the corresponding Disabled/Non-Disabled/Newly Non-Disabled and Not-Newly Non-Disabled populations to create the MEGs for reporting purposes.

Effective January 1, 2018 (beginning in the third quarter of P1) Chelan, Douglas and Grant counties (North Central BHO) were removed from the managed care program as they shifted to the FIMC program. Enrollment for the various MEGs is adjusted for the removal of these three counties.

Effective January 1, 2019, (beginning in the third quarter of P2) there will be two key changes to the BHO program:

- The first is that the counties in the Greater Columbia, King, Pierce, and Spokane BHOs will be removed from the behavioral health managed care program as they shift to the FIMC program. Enrollment for the various MEGs is adjusted for the removal of the counties in these BHOs.
- The second is that Foster Care population will be removed from the behavioral health managed care program and transition into a single statewide managed care entity covered under a separate contract. Enrollment for the various MEGs is adjusted for the removal of this population.

Please note, as the BHSO population was effective April 1, 2016, R2 member months for all MEGs reflect actual BHSO population enrollment for two quarters of data (April – September 2016), compared to four quarters of BHO population data for time period R2.

The caseload forecasts for Medicaid eligible people are created by the Caseload Forecast Council. They are created for each eligibility group. The primary distinctions are Categorically Needy: Grant-Receiving Adults and Children, Non-Grant Pregnant Women, Non-Grant Children, SSI and SSI-Related; Medically Needy: Aged and Disabled; and State-Funded Medical Care Services. These forecasts include the Medicaid expansion population effective January 2014 related to the Affordable Care Act. The models are generally simple time series models or entry/exit projections of a “primary” or base trend plus the addition of “steps” or interruptions to the base trend. These interruptions are generally state or federal law or program changes. The models are calculated and presented to a group of staff from the Executive and Legislative branches with the intention of reaching consensus on the results.

Additionally, the State provided FFS enrollment levels for the BHSO population to use for the third and fourth quarters of R2 as well as for projecting P1-P5.

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

There are no other variances in the member month projections.

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

R1 is FFY 2015 quarter 1 through FFY 2015 quarter 4 (10/14 – 9/15) and R2 is FFY 2016 quarter 1 through FFY 2016 quarter 4 (10/15 – 9/16).

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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:

Retrospective Year 2 (FFY 2016) includes both experience under the RSN program (FFY 2016 Q1-Q2) as well as experience under the BHO structure (FFY 2016 Q3-Q4). Additionally, FFY 2016 quarters 3 and 4 reflect experience for the BHSO populations, as they were effective April 2016. Base data adjustments are applied in Appendix D5 to adjust the entire Retrospective Year 2 time period to be consistent with FFY 2016 quarters 3 and 4 reflective of the BHO program experience as well as actual BHSO program experience. Additional information is included in the Appendix D4 narrative below.

- b. **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**

For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For mental health-related services, only state-only funded services are not included in the analysis. WA used audited CMS 64 waiver reports for the basis of the analysis. Through ongoing analysis, certain costs were identified that need to be added that had not been initially reported on the CMS 64 waiver reports. These costs have been added to Appendix D3 and are discussed later in this preprint.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Inpatient Hospital							
Outpatient Hospital Services (other than Lab & X-ray)							
Rural Health Clinic Services (Contracting Facilities Only included in 1915(b) Waiver Cost							
Federally Qualified Health							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Center Services (Contracting Facilities Only in 1915(b) Waiver Cost)							
Prof. & Clinic and other Lab and X- ray (ITA only included in 1915(b) Waiver Costs)							
EPSDT, including Chiropractic (only mental health component included in 1915(b) Waiver)							
Physicians' Services (Psychiatrist)							
Practitioners' Services, Other (Psychologists)							
Prescribed Drugs (Pharmacy)							
Chemical Dependency Service: Department Approved Alcohol/Drug Residential Treatment Centers							
Chemical Dependency Service: Detoxification							
Chemical Dependency Service: Opiate Substitution Treatment							
Chemical Dependency Service: Outpatient							
Mental Health Service - Brief Intervention Treatment							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Mental Health Service - Crisis Services							
Mental Health Service - Day Support							
Mental Health - Family Treatment							
Mental Health Service - Freestanding Evaluation and Treatment							
Mental Health Service - Group Treatment Services							
Mental Health Service - High Intensity Treatment							
Mental Health Service - Intake Evaluation							
Mental Health Service - Medication Management							
Mental Health Service - Medication Monitoring							
Mental Health Services provided in Residential Settings							
Mental Health Service - Peer Support							
Mental Health Service - Psychological Assessment							
Mental Health Service - Rehabilitation Case Management							
Mental Health Service - Special							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Population Evaluation							
Mental Health Service - Stabilization Services							
Mental Health Service - Therapeutic Psychoeducation							
Behavioral Rehabilitation Services							
IMD Services for Age 65 and Older							
Inpatient Psychiatric Services (Under 21 Year of Age)							
Psychologist (Service may be FFS or through Inpatient Hospital)							
Inpatient Hospital							
Other Lab & X-ray Services							
Medical & Surgical Services Performed by a Dentist							
Podiatrists' Services							
Vision Care Services and Eyeglasses							
Licensed Midwives and Nurse Midwives							
Home Health Care Services							
Private Duty Nursing Services							
Clinic Services - Freestanding Kidney Centers Chronic Dialysis Centers							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Dental Services							
Physical Therapy							
Occupational Therapy							
Speech Therapy							
Dentures							
Durable Medical Equipment Includes Prosthetic Devices, Excludes Hearing Aids							
Hearing Aids							
Preventive Services							
Rehabilitation Treatment Services							
Nurse Midwife							
Education Agency Services (School- Based Services for Special Family Preservation Services)							
Family Preservation Services							
Freestanding Birth Centers							
Intermediate Care Facility Services (other than an IMD)							
Intermediate Care Facility Services (in an IMD)							
Developmental Disabilities Services (part of ICF/MR) Developmental Hospice							
Targeted Case Management Services							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Extended Services for Pregnant Women							
Family Planning Services							
Obstetrical Services							
Respiratory Care							
Certified Pediatric or Family Nurse Practitioner Services							
Transportation							
Skilled Nursing Facility Services (Under 21 years of Age)							
Emergency Services (Outpatient Hospital Service)							
Personal Care							
PACE							

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

- The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees *Note: this is appropriate for MCO/PCCM programs.*
- The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- Other**
Please explain:

The administrative costs reflected on Appendix D3 are pulled directly from the CMS 64.10 waiver forms. These expenses are for specific contracts or allocated staff working directly on the BHO waiver program. In addition, the State identified expenses for the EQRO contractor, CLIP administration, Disability Rights WA, T.R. Settlement, and actuarial contracts that are not included in the waiver report. These expenses have been identified and included in the reported waiver expenses in column K of Appendix D3.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

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

- 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**

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

The State does not provide stop/loss protection nor require PIHPs to purchase private reinsurance coverage. In addition to the taxing authority of the counties, the State requires that each BHO hold risk and claim reserves for the sole purpose of ensuring solvency.

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

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

Document

- i. **Document the criteria for awarding the incentive payments.**

- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

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

Document:

- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

- 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. [Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

The actual trend rate used is:

Please document how that trend was calculated:

From the end of R2 to the beginning of P1, trends were reviewed for capitated, BH pharmacy and other FFS wraparound services. Excluding pharmacy, Mercer observed a PIHP capitation and FFS trend of 4.4% for the most recent 5 quarters through FFY 2016 Q2 compared to the previous 4 quarters. FFY 2016 Q3 and Q4 PIHP expenditures include the program redesign to include coverage of SUD services through managed care. As such, trends from FFY 2016 Q2 to Q3/Q4 were over 4.4% and not reflective of realistic future trends. For the capitated and FFS services, Mercer used an annual trend rate of 4.1%, consistent with the prospective trend used to develop the WA BHO capitation rates for state fiscal year (SFY) 2017/2018, for the period between R2 and P1. This 4.1% trend assumption is generally consistent with the observed trend in historical reported waiver costs. The prospective trend analysis for the BHO capitation rates was based on observed ramp up of SUD service utilization in recent months of BHO experience.

2. **[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. State historical cost increases.

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

The base period for developing the waiver projections is October 1, 2015 through September 30, 2016. Mercer considers historical year over year trends, as well as rolling averages in making these estimates.

For base periods R1 through FFY 2016 Q2 of R2, the PIHP capitated and FFS (excluding pharmacy) service trend indicates roughly 4.4% annual trend. Mercer observed decreasing pharmacy expenses that appear to be approaching minimal yet more stable levels in recent quarters. In the assessment of prospective trends pharmacy expenses were to remain fairly stable as indicated in recent quarters. As noted above, FFY 2016 Q3/Q4 PIHP capitated service trends were significantly higher due to the inclusion of SUD services under managed care and as such were not considered reasonable for purposes of prospective trend development.

For the waiver trend projection, Mercer leveraged the trend analyses from the actuarial rate development, which observed increases in SUD utilization in more recent months of BHO experience, and quarterly analysis of FFS trends. Mercer utilized a trend rate of 4.1% to project the R2 experience to the P1 through P5 time periods, which is generally consistent with the historical trend observed in the reported waiver expenditures. Trend estimates do not duplicate the effect of any programmatic, policy or pricing changes.

ii. National or regional factors that are predictive of this waivers future costs.

Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

In addition to Washington-specific data sources, Mercer also considers national indices (Consumer Price Index and Producer Price Index).

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.

Mercer did not estimate cost changes separate from the utilization changes. Trend estimates do not duplicate the effect of any programmatic changes.

Appendix D4 Adjustments in Projection

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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. 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
 - Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
 - Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.
1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
 2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

Base Data Adjustment for Reflection of BHO/BHSO Program
Kick Payment
Budget Initiatives
Substance Use Disorder Per Diem Repricing
FIMC Transition
SUD 1115

For the list of changes above, please report the following:

- A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

0.00

- B.** The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

0.00

- C.** Determine adjustment based on currently approved SPA.

PMPM size of adjustment

0.00

- D.** Determine adjustment for Medicare Part D dual eligibles.

- E.** Other:

Please describe

See 1. Attached spreadsheet tab D4 and narrative in attached Appendix J D4 - Conversion or Renewal Waiver Cost Projection and Adjustments and 2. Attached "D4 Section J Narrative Attachment"

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

- iii.** Changes brought about by legal action:

Please list the changes.

For the list of changes above, please report the following:

- A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B.** The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

- C.** Determine adjustment based on currently approved SPA.

PMPM size of adjustment

- D.** Other

Please describe

- iv.** Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

- A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B.** The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

- C.** Determine adjustment based on currently approved SPA

PMPM size of adjustment

- D.** Other

Please describe

- v.** Other
Please describe:

- A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B.** The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

- C.** Determine adjustment based on currently approved SPA.

PMPM size of adjustment

- D.** Other

Please describe

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

- ii. Cost increases were accounted for.
 - A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. State Historical State Administrative Inflation. The actual trend rate used is PMPM size of adjustment

0.00

Please describe:

- D. Other
Please describe:

To distribute administration expenses amongst the Disabled, Non-Disabled and Newly Non-Disabled and Not-Newly Non-Disabled MEGs (inclusive of the BHSO populations), Mercer used a casemix of the medical component of the CMS 64 figures to proportionately assign administrative expenses. On a percentage basis, the administrative costs do not vary by MEG.

- 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

October, 2015 through September,

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 States 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

4.10

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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 States 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 States 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 lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

- i. A. State historical 1915(b)(3) trend rates

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

2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.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:

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p. Other adjustments including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included

in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

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

Please describe:

1. No adjustment was made.
2. This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

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K. Appendix D5 Waiver Cost Projection

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

Spreadsheets are attached.

Appendix D5 Waiver Cost Projection

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L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

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M. Appendix D7 - Summary

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

Overall, the variance in spending between R1 and P2 is impacted by inflationary cost increases and program change impacts described in greater detail previously.

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:

Enrollment projections are based on historical enrollment trends and expectations for enrollment changes based on recent economic conditions. The changes in enrollment are primarily due to changes in economic conditions and general increases in the population. These forecasts include the Medicaid expansion population effective January 2014 related to the Affordable Care Act. Effective April 1, 2016, these projections are also adjusted for to account for the transition of Clark and Skamania counties to FIMC / BHSO, as well as the January 1, 2018 transition of the North Central BHO to FIMC / BHSO and January 1, 2019 transitions of the Greater Columbia, King, Pierce, and Spokane BHOs, as described above. The projections also reflect the transition of the Foster Care population to the single statewide managed care entity effective January 1, 2019.

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 States explanation of cost increase given in Section D.I.I and D.I.J:

Mercer did not estimate cost changes separate from the utilization changes. Trend estimates do not duplicate the effect of any programmatic changes.

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 States explanation of utilization given in Section D.I.I and D.I.J:

Mercer did not estimate cost changes separate from the utilization changes. Trend estimates do not duplicate the effect of any programmatic changes.

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

Appendix D7 - Summary