CMS DRAFT FORM

Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal

Requested effective date April 1, 2006

Washington State Integrated Community Mental Health Program
April 1, 2006- March 31, 2008

Submitted by:
Washington State
Department of Social and Health Services
Mental Health Division
Mary Anne Lindeblad, Interim Director

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

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PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Waiver Renewal Submittal

Section A. GENERAL INFORMATION

The **State of Washington** requests a waiver under the authority of Section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

Effective Dates: This waiver renewal is requested for a period of 2 years; effective April 1, 2006 and ending March 31, 2008.

The waiver program is called Integrated Community Mental Health Program.

State Contact: The State contact person for this waiver is Chris Imhoff who can be reached by telephone at (360) 902-0803, or fax at (360) 902-0809, or e-mail at imhoffc@dshs.wa.gov.

I. Statutory Authority

a. Section 1915(b)(1): The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

b. Other Statutory Authority: The State is also relying upon authority provided in the following section(s) of the Act:

1. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2. _X__**1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list in Section A.IV .d.1 and Appendix D.III additional services to be provided under the waiver, which are not covered under the State plan. 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.

3. _X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified ~~provider~~ *Community Mental Health Agencies (CMHA*s) 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. Please refer to Section 2105 of the State Medicaid Manual.

c. **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:

1. _X_ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State~~.~~ ~~This waiver program is not available throughout the State.~~ *This waiver program is implemented statewide. It may be necessary however; if at any time the RSN can not, or chooses not, to demonstrate qualifications, for the State of Washington to implement a fee for service system on a time-limited basis to implement a procurement process for that geographic area. This would be done thoughtfully as covered in the contingency plan submitted to CMS to not disrupt care to consumers.*

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

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

4. _X_ **Section 1902(a)(4)** – To permit the State to mandate beneficiaries into a single PIHP or PAHP.

5. _X_ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

Section 438.52 Non-competitive Procurement - The MHD continues to rely on its agreement with the Centers for Medicare and Medicaid Services that the Regional Support Networks (RSN) have the first opportunity to contract to operate the PIHP for

outpatient mental health services and community mental health inpatient services.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created county-based RSNs to design and administer mental health delivery systems, receive available resources and to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering mental health services under a 1915 (b) waiver in 1993, for outpatient mental health services and for integrated community mental health in 1997. The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This established the ability to control the rate of financial growth and improved mental health service outcomes.

The first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks. The first opportunity provision was contingent upon the RSNs agreement to enter into a full-risk capitation contract at an actuarially sound rate determined by the MHD. RSNs were also required to demonstrate capacity to meet the program and fiscal requirements. The RSNs administer the Medicaid mental health care system directly, or subcontract with qualified community mental health agencies (CMHA). Such subcontracts do not relieve the RSNs of ultimate responsibility for compliance with the MHD's program and fiscal requirements. RSNs may impose additional requirements on subcontractors as may be needed to affect appropriate management oversight and flexibility in addressing local needs.

Pursuant to the State's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Statutes (RCW 71.05 and RCW 71.34), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as services for people with developmental disabilities. All RSNs must meet the certification requirements of RCW 71.24 and the requirements of RCW 48.44 (the insurance code), as applicable.

If an RSN chooses not to participate, or is unable to meet required qualifications, the MHD will secure an alternate contractor. This would be done thoughtfully as covered in the contingency plan submitted to CMS to avoid disruption of care for consumers.

The MHD ensures that whether a county-based PIHP or other entity holds the mental health managed care contract, that contractor is required to provide a cost effective, integrated system of mental health service delivery.

Section 438.52 Choice – All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP covering a specific catchment area. The state is requesting authority to waive 438.52.

II. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

Brief Summary

The purpose of this waiver renewal is to continue to: 1) promote age, culturally, and linguistically competent, coordination of comprehensive mental health services with regionally managed care through Prepaid Inpatient Health Plans (PIHP); 2) provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner providing continuity of care for persons served by the public mental health system; and 3) support recovery and reintegration to the community for persons with mental illness.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created county-based RSNs to design and administer mental health delivery systems to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering mental health services under a 1915 (b) waiver in 1993, for outpatient mental health services. The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This established the ability to control the rate of financial growth and improved mental health service outcomes. The mental health services covered under the waiver are the full range of community mental health rehabilitation services offered under the Medicaid State Plan through a fee-for-service reimbursement system. These mental health services stress ongoing community support to provide the enrollee with

tailored services that are responsive to individual needs. It is the State's intention to manage the costs of the community program while continuing to target service to the most disabled enrollees. It is also the State's intention to utilize the managed care principles to provide Medicaid eligible persons with mental health services necessary to promote community reintegration and consumer recovery.

In 1997, an amendment to the existing waiver was approved which incorporated community psychiatric inpatient services for Medicaid eligible adults, older persons, and children into the capitated contracts with the RSNs. This integration furthered the principles of mental health reform and improved the services provided to enrollees. An essential component of the waiver amendment was to provide the RSNs the first opportunity to demonstrate qualifications and enter into an integrated full-risk capitated mental health services contract with the MHD. The MHD took this approach due to the existing unique structure of mental health and human service delivery systems administered by counties and the RSNs under state law. Pursuant to the State's Community Mental Health Services Act, the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act, the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as providing services for people with developmental disabilities.

The statewide mission and values are the basis of all aspects of mental health service delivery, interpretation, and implementation of the waiver and the RSN contracts.

Mission Statement

The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community.

We are committed to take actions consistent with these values:

1. We value the strengths and assets of consumers and their families, and seek to include their participation in decision-making and policy setting.
2. We respect and celebrate the cultural and other diverse qualities of each consumer.
3. We work in partnership with allied community providers to deliver quality-individualized supports and services.
4. We treat people with respect, equality, courtesy and fairness.

Significant Legislation

During this waiver period, there has been considerable emphasis on the public mental health system in Washington State. The legislature established a Mental Health Task Force with a focus on funding, services, and coordination activities. Membership on the task force and related sub-committees included legislators, mental health consumers, advocates, providers, RSNs, the state Medicaid agency, and allied system partners. Meetings were open to the public and resulted in a number of

recommendations for the the mental health system in the following areas: funding, residential capacity, expedited eligibility, mental health courts, accountability, and evidence-based practices.

The task force is continued throught the 05-07 biennium and is expected to continue contributing to oversight and planning for the mental health system.

The 2005 legislature passed two major bills related to the mental health system and the work of the task force. While it is premature to predict the full impact on the mental health system, both bills promote increased accountability, coordination of care and a culture of recovery.

1) Engrossed Second Substitute House Bill 1290 (E2SHB 1290) mandates the following:

- Consumer, family member, and advocate participation in all aspects of service delivery.
- Provision of services that emphasize resilience and recovery.
- Access to evidence-based, research-based, and consensus-based practices.
- Collaboration with Justice and chemical dependency services.
- Expidited Medicaid eligibility determinations for persons leaving jails and prisons.
- The department is required to enter into a two step procurement process to establish Regional Support networks. In the first step, existing RSNs may respond to a Request for Qualifications (RFQ) developed by the Department. An existing RSN is awarded a contract if it substantially meets requirements of the RFQ. If a current RSN does not respond to the RFQ or fails to meet qualifications, the department is required to develop a Request for Proposals in which other entities recognized by the secretary may bid to be the Regional Support Network. To keep to the mandated timelines, the department will announce results of the RFQ by January 15, 2006. If necessary, an RFP will be issued by March 1, 2006.

2) Engrossed Second Substitute Senate Bill 5763 (E2SSB 5763), addresses the need to provide integrated treatment and reduce the disproportionate number of persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders who are in correctional institutions, homeless, or become involved with child protective services.
   - Pilots an integrated initial detention process for persons with mental health and substance abuce disorders.
   - Pilots intensive case management of chemically dependent persons who are high utilizers of emergency and crisis services.

- o Expands chemical dependency services for Medicaid eligible persons with an emphasis on persons identified through children and family services.
- o DSHS is required to adopt a comprehensive, integrated screening and assessment process for mental illness and chemical dependency.

Transformation Grant
The state of Washington is the recipient of one of seven federal Mental Health Transformation Incentive Grants awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The efforts of this five-year, $14 million Transformation Initiative around outreach, education and training, policy formation, evaluation and public education campaigns will result in a more effective and efficient mental health system that provides high-quality, integrated services that are responsive to the specific needs of consumers, their family members, and youth. This grant was written with considerable input from the stakeholder community.

Governor Christine Gregoire of the State of Washington is leading *Partnerships for Recovery* with the full support and participation of the Director of every Department and Division serving people with mental illness in the State of Washington. With consumers and family members as equal partners, Partnerships for Recovery has launched a deep transformation effort to achieve the goals of the President's New Freedom Commission.

Key elements of the initiative include:

1. A social marketing initiative to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and promote support for people with mental illness in the community and workplace.
2. Strengthening of the statewide infrastructure for consumer and family support and advocacy
3. Development of a comprehensive approach to insure participation of consumers as service providers.
4. Reduction of ethnic and geographic disparities and enhancement of the cultural competence of all systems.
5. Adoption of a strengths-based, consumer-driven care planning model in all state departments serving people with mental illness.
6. Implementing training and fiscal and regulatory incentives for the expanded use of evidence-based recovery focused practices.
7. Development of a web-based data infrastructure that will support direct service, planning, and evaluation and form a basis for system wide accountability to citizens and consumers.
8. Development of a consumer-driven formative, process, and outcome evaluation.

<u>Other stakeholder involvement includes:</u>

- **The MHD Office of Consumer Affairs** (OCA), in the MHD, meets quarterly with consumers, parents, and advocates. Frequent and consistent communication assures an accurate understanding of the points of view of consumers, parents, and other family members, which is then incorporated into the workings of the public mental health system. The OCA Director is a member of the MHD Management Team.
- **The Consumer Roundtable** includes a consumer representative from each RSN who

receives public mental health services. Consumers in recovery act as mentors with this group to provide assistance and advice as they assume their role as active participants. This group provides direct input to management via OCA.

- MHD contracts with family advocacy groups statewide for education and advocacy purposes. These groups are also very visible during the state's legislative session.
- MHD supports and meets bimonthly with SAFE Washington, a parent council, consisting of parents/caregivers of minor children who receive services through the public mental health system. Each represents a parent organization in their RSN or the Community Connector Project sponsored by the MHD. SAFE Washington provides input to the MHD Director.
- Consumers and family members make-up 51% of the state mental health planning and advisory council (MHPAC). This council includes representatives who are advocates for children and for older adults with mental illness, RSNs, service providers and representatives of allied systems. The council meets 8 times a year and are active participants in MHD planning and evaluation activities.
- MHD staff meets quarterly with the Department of Social and Health Services (DSHS) Indian Policy Advisory Committee (IPAC) to share information and to discuss strengths and concerns. Its role is to assist the collective needs of the Tribal governments and other American Indian organizations to assure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State.
- MHD and the Division of Alcohol and Substance Abuse (DASA) staff the co-occurring disorders interagency committee (CODIAC) made up of representatives from state agencies, mental health and chemical dependency providers, and consumers from both systems. This group addresses co-occurring mental illness and substance related disorders, system and treatment issues.
- MHD meets with the Washington Community Mental Health Council (WCMHC) monthly. This provider organization represents 85% of the community mental health agencies providing services under subcontract with the RSNs. The MHD also receives input from the community mental health agencies that do not belong to the WCMHC but subcontract with the RSNs.
- DSHS Secretary Robin Arnold Williams has hosted two statewide stakeholder meetings to gather input into the design of the public mental health system, to plan for transformation and to discuss internal reorganization which combines the Mental Health Division, the Division of Alchol Substance Abuse and the Medical Assistance Administration into the Health and Recovery Services Administration.

While this waiver renewal application does not make major changes to the program, consumer groups have requested two changes that are incorporated in the request. (1) A change in the definition of Supported Employment that allows consumers to receive this mental health related service while they are on the waiting list for the Division of Vocational Rehabilitation and;
(2) A requirement for some evening/weekend hours for Mental health Clubhouse services.

The stakeholder groups listed above are also participating in the development and evaluation of the mental health request for qualifications and related contracts.

III. General Description of the Waiver Program

a. Type of Delivery Systems: The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PIHP program for a mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully).

1. ___ **Risk-Comprehensive (fully-capitated—MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as 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. Check either (a) or (b), and within each the items that apply:

   (a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

   i.___ Outpatient hospital services,
   ii.___ Rural health clinic (RHC) services,
   iii.___ Federally qualified health clinic (FQHC) services,
   iv.___ Other laboratory and X-ray services,
   v.___ Skilled nursing facility (NF) services,
   vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
   vii.__ Family planning services,
   viii.__ Physician services, and
   ix.___ Home Health services.

   (b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a).

2. _X_ **Partial Risk (PIHP/PAHP):** Other risk contracts are those that have a scope of risk that is less than comprehensive. The contractors in these programs are either PIHPs or PAHPs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs/PAHPs generally apply to these other risk entities. For PIHPs, please check either (a) or (b); if (b) is chosen, please check the services that apply. For PAHPs, please check (b), and indicate the services that apply.

   (a)__ The contractor is a PIHP at-risk for all inpatient hospital services, or

   (b)__ The contractor is a PIHP or PAHP at-risk for two or fewer of the

below services ((i) through (x)).

i. _X_ Outpatient ~~hospital~~ *community mental health rehabilitation* services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services
ix.___ Home Health services.
x. _X_ Other: ___ dental
___ transportation
_X_ a subset of *community mental health* inpatient hospital services (e.g. only mental health admissions)

3. ___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., a PIHP contract where the State performs a cost-settlement process at the end of the year). Please provide a brief narrative description of non-risk model, which will be implemented by the State.

4. ___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

b. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to CMS):

1. _X_ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2. ____ Other (please list in the table below):

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

City/County/Region	Name of Entity*	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
Chelan, Douglas	Chelan/ Douglas Regional Support Network	PIHP
Clark	Clark County Regional Support Network	PIHP
Grays Harbor	Grays Harbor Regional Support Network	PIHP

City/County/Region	Name of Entity*	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
Asotin, Garfield, Klickitat, Kittitas, Yakima, Benton, Franklin, Skamania, Walla Walla, Columbia, Whitman	Greater Columbia Behavioral Health Regional Support Network	PIHP
King	King County Regional Support Network	PIHP
Adams, Grant, Okanogan	North Central Regional Support Network	PIHP
Stevens, Lincoln, Pend Orielle, Ferry	Northeast Washington Regional Support Network	PIHP
Skagit, San Juan, Island, Snohomish, Whatcom	North Sound Regional Support Network	PIHP
Clallam, Jefferson, Kitsap	Peninsula Regional Support Network	PIHP
Pierce	Pierce County Regional Support Network	PIHP
Cowlitz	Southwest Regional Support Network	PIHP
Spokane	Spokane Regional Support Network	PIHP
Thurston, Mason	Thurston Mason Regional Support Network	PIHP
Lewis, Pacific, Wahkiakum	Timberlands Regional Support Network	PIHP

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

- **Requirement for Choice:** Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.

1. ___ This model has a choice of managed care entities.
   - (a)__ At least one MCO and PCCM (please use the combined PCCM Capitated Waiver Renewal Preprint)
   - (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM Waiver Renewal preprint)
   - (c)__ Two or more MCOs
   - (d)__ At least one PIHP or PAHP and a combination of the above entities

2. ___ This model is an HIO.

3. ___ The State is opting to use the exception for rural area residents in Section 1932(a)(3) and 42 CFR 438.52(b). Please list the areas of the State in which the rural exception applies:

4. _X_ The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP *for their geographic area.*

c. **Waiver Population Included:** The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. **X** Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. **X** Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) *except for those women in the family planning waiver (program S, medical code P and Z).*

3. **X** Blind/Disabled Children and Related Populations (SSI)

4. **X** Blind/Disabled Adults and Related Populations (SSI)

5. **X** Aged and Related Populations (Please specify: SSI, QMB Plus, SLMB Plus, and all state buy in.)

6. **X** Foster Care Children

7. **X** Title XXI SCHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8. ___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9. **X** Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)
   - i. ___ Children with special needs due to physical and/ or mental illnesses,
   - ii. ___ Older adults,
   - iii. ___ Foster care children,
   - iv. ___ Homeless individuals,
   - v. **X** Individuals with serious and persistent mental illness ~~and/or substance abuse,~~
   - vi. ___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
   - vii. __ Other (please list):

Please see Attachment A.III.d. for Access to Care Standards Eligibility Requirements for Authorization of services for Medicaid eligibles. Access to Care Standards became effective August 1, 2003.

The PIHPs are expected to meet the mental health needs of the consumers they serve. They are encouraged to provide innovative and flexible supports. Services are to be provided by a community mental health agency that is licensed and or certified by the

state. All services are to be provided by or under the supervision of a mental health professional.

The MHD wishes to continue with an amended definition in 438.2: Health Care Professional. In addition to the definition specified 438.2, the MHD requests the definition be expanded to include Mental Health Professional and mental health specialists as described in Washington Administrative Code (WAC) 388-85-0150, or its successor under this waiver. This will allow the public mental health system to continue to have qualified staff perform authorization to mental health service, second opinion, grievance and appeal functions appropriate to their scope of practice and experience and allow the effective use of mental health professionals

Primary Care definition is not applicable to mental health.

Mental Health Care Provider (MHCP) means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services.

Provider for this waiver renewal is a Community Mental Health Agency (CMHA)

Intensity for this waiver renewal is the same as Duration and Scope. Duration is the period of time and scope means the range of services (e.g. which state plan services an individual would receive if offered in a fee-for-service system).

Amount is defined as the number of sessions.

Availability of providers is defined as: sufficient to meet the demand

Adequate capacity means that the provider can handle the volume or meet the demand

Attachment A.III.d.

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

*** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support

CMS draft form

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders. * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. * The individual is expected to benefit from the intervention. * The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
- * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
- * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- * The individual is expected to benefit from the intervention.
- * The individual's unmet need can not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders. * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. * The individual is expected to benefit from the intervention. * The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:

- * The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
- * The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
- * The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- * The individual is expected to benefit from the intervention.
- * The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer’s Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer’s Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer’s Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer’s Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson’s Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson’s Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington’s Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington’s Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick’s Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick’s Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B

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DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State

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Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A

	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	

300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B

301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.
[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
- Two or more hospital admissions due to a mental health diagnosis during the previous two years
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

End of Attachment A.III.d.

d. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. __X__ Have Medicare coverage, except for purposes of Medicaid-only services (pure QMB, pure SLMB, expanded SLMB, qualified disables and working individuals[QDWI]);

2. ___ Have medical insurance other than Medicaid;

3. ___ are residing in a nursing facility;

4. **_X_** are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. ___ are enrolled in another Medicaid managed care program;

6. ___ have an eligibility period that is less than 3 months;

7. **_X_** are in ~~a poverty level eligibility category for pregnant women~~ *program code S, medical codes P and Z in which eligiblility is for pregnant women for the family planning waiver only.*

8. ___ are American Indian or Alaskan Native;

9. ___ participate in a home and community-based waiver;

10. __ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12. __ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in l. above are listed here (Please explain further in Section F. Special Populations if necessary);
    i. ___ Children with special needs due to physical and/ or mental illnesses,
    ii. ___ Older adults,
    iii. ___Foster care children,
    iv. **_X_** Homeless individuals *for whom no Medicaid reimbursement is received*,
    v. ___ Individuals with serious and persistent mental illness and/or substance abuse,
    vi. ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
    vii. **_X_**Other (please list):

Residents of State psychiatric hospitals, the Children Long Term Inpatient Program, persons enrolled in the PACE program, persons enrolled in the Washington Medicaid Integration Project for their mental health needs are excluded from the capitation system and paid through other means.

Persons enrolled in the Washington Medicaid Integration Project have the option to "opt-out" and continue to receive mental health services from the Regional Support Network.

13. __ have other qualifications which the State may exclude enrollees from

participating under the waiver program. Please explain those reasons below:

e. **Automated Data Processing:** Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

f. **Independent Assessment:** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. ___ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.

2. _X_ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

IV. Program Impact

In the following informational sections, please complete the required information to describe your program.

a. **Marketing** including indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). *Information to potential enrollees and enrollees (i.e., member handbooks), is addressed in Section H.*

Previous Waiver Period

1. ___ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period.

1.___ The State does not permit direct or indirect MCO//PIHP/PAHP marketing (go to item “b. Enrollment/Disenrollment”)
2.___ The State permits indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general). Please list types of indirect marketing permitted.
3.___ The State permits direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:
5.___ The State permits MCOs/PIHP/PAHPs 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:
6.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check those that apply):
i. __ The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.
ii.__ The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately ___ percent or more of the population.
iii.__ Other (please explain):

7.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **Required Marketing Elements**: Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.
Marketing requirements do not apply for the following reasons:
⇒ Enrollment is this waiver is mandatory and automatic for Medicaid eligibles. There is no disenrollemnt.
⇒ RSNs must serve all enrollees who meet medical necessity including access to care standards.
⇒ There is a single PIHP for each geographical area.

The State:
(a)__ Ensures that all marketing materials are prior approved by the

State

(b)__ Ensures that marketing materials do not contain false or misleading information

(c)__ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials

(d)__ Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service area

(e)__ Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)___ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-to-door, telephonic, or other forms of “cold-call” marketing.

(g)__ Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements. Please include the results from those monitoring efforts for the previous waiver period. (Reference items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint; items A.III.b Upcoming Waiver Period of 9/23/99 Waiver Renewal).

   Disenrollment has been waived in our waiver modification submitted in August 2003. The state has mandatory enrollment, does not operate an alternate fee-for-service system.

Upcoming Waiver Period - Please describe the State’s enrollment process for MCOs/PIHPs/PAHPs by checking the applicable items below.

1. ___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2.___ **Administration of Enrollment Process**:

(a)__ State staffs conduct the enrollment process.

(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: __________________

ii. Procurement method:

(A). ____Competitive

(B). ____Sole source

iii. Please list the functions that the contractor will perform:

(c)__ State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_X_ Mandatory for populations in Section A.III.d

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4. **Enrollment:**

(a)__ The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs/PAHPs and providers based on their medical needs. Please describe.

(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:

i. ___ mail

ii.___ phone

iii.___ in person at ____
iv.___ other (please describe):

(d) **NA mandatory enrollment** [Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)__ If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?

(h)__ The State provides guaranteed eligibility of ____ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)__ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.
i. ___ Enrollee submits request to State
ii. ___ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State plan may not disapprove the request).

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

iv. ___ [Required] Regardless of whether plan or State makes 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.

(b) **_X_** The State does not allow enrollees to disenroll from the only available PIHP/PAHP.

(c)__ The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.

ii.___ MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO/PIHP/PAHP enrollees who have the following good cause reasons for disenrollment are allowed to disenroll during the lock-in period:

A. __ [Required] Enrollee moves out of plan area
B. __ [Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks
C. __ [Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk
D. __ [Required] Poor quality of care
E. __ [Required] Lack of access to covered services
F. __ [Required] Lack of access to providers experienced in dealing with enrollee's health care needs
G. ___ Other: (please list)

iv. __ [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.

(e)__ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.

(f) __ [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PIHP/PAHP.

6. **MCO/PIHP/PAHP Disenrollment of Enrollees**: If the State permits MCOs/PIHPs/PAHPs to request disenrollment of enrollees, please check items below that apply:

(a)__ [Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:

(b)__ The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.

(c)__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP to remove the enrollee from its membership.

(d)__ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

c. Entity Type Or Specific Waiver Requirements

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period.

1._X_ **Required MCO/PIHP/PAHP Elements:** MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq. *Unless waived*

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting authority under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a) **X** The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i. **X** Although the organization of the service delivery and payment mechanism for that *mental health* service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan. *This is not different from the current system but is different from the fee-for-system. State plan services are attached as Attachment A.IV.c.2.a.i.*

ii. **X** MCO/PIHP/PAHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. **X** MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv.___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. **X** There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

Attachment A.IV.c.2.a.i
State plan approved services

1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

2) Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

3) Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

4) Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

5) "Freestanding Evaluation and Treatment" Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

6) Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills,

mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

7) <u>High Intensity Treatment</u>: Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members' work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.
*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

8) <u>Individual Treatment Services</u>: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

9) <u>Intake Evaluation</u>: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a

mental health professional.

10) Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

11) Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

12) Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

13) Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes

document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

14) Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

15) Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

16) Special Population Evaluation: evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

17) Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

18) Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through

knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

End of *Attachment A.IV.c.2.a.i*

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:

(a) The State has used/will use a competitive procurement process. Please describe.

(b)__ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c) **X** The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

Please see waiver request above.

Engrossed Second Substitute House Bill 1290 requires the state to issue a Request for Qualifications (RFQ) to existing RSNs in October 2005 with the response submittal due December 1, 2005. At the time of this renewal the review and evaluation of the responses is occurring. Should the existing RSNs not meet the standards defined in the RFQ, the state is then directed to issue a Request for Proposal (RFP) March 1, 2006 to all interested parties. Either contract will be awarded effective September 1, 2006.

4._**X**__Per Section 1932(d) of the Act and 42 CFR 438.58, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO/PIHP/PAHP contracts and the default

enrollment process established for MCOs/PIHPs/PAHPs.

d. Services
Previous Waiver Period

1.**_X_** [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with *mental health* service provision requirements. Please include the results from those monitoring efforts for the previous waiver period. [Reference: items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d. Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

PIHPs must also ensure system capacity to provide a full range of mental health services to the individual enrollee's needs in a way that provides for seamless coordination and continuity of services. These mental health services should provide for the least amount of disruption in the consumer's life and support recovery and community reintegration.

The MHD monitors services in a variety of ways. In addition to the annual on-site monitoring activities of the EQRO, & the MHD contract monitoring, there are the meetings with stakeholders as described, additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys.

The EQRO report was submitted to CMSRegion X in March 2005. The report can be accessed at: http://www1.dshs.wa.gov/Mentalhealth/publications.shtml .

EQRO on site visits to RSNs for the current year are taking place in December 2005.

The Performance Indicator report may be found at http://www1.dshs.wa.gov/mentalhealth

The child and adult satisfaction survey have been conducted. Results and comparisons of consumer surveys may be found at http://depts.washington.edu/washinst .

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period.

1._X__Please list in Appendix D.2.S the Medicaid services MCOs/PIHPs/PAHPs will be responsible for delivering, prescribing, or referring. Instructions for this Appendix can be found in Section D. Cost Effectiveness, III. Instructions for Appendices.

Supported employment is a service for Medicaid enrollees who are not currently receiving federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include;
  - (a) Consumer strengths
  - (b) Consumer abilities
  - (c) Consumer preferences
  - (d) Consumer's desired outcomes
- Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- Services are provided by or under the supervision of a mental health professional

Respite Care is a service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary care givers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.

- Mental Health Clubhouse: A service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees. These services provided at a clubhouse may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Mental health Clubhouse must operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday.

Services include the following:

- Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.

- Opportunities to participate in administration, public relations, advocacy and evaluation of

clubhouse effectiveness.

- Assistance with employment opportunities; housing, transportation, education and benefits planning.

- Opportunities for socialization activities.

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(a)__ The State has a more stringent definition of emergency medical condition for MCOs/PIHPs/PAHPs than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)__ The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)__ The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*

i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.___ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.___ Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

iv.___ Continued emergency services until the enrollee can be safely discharged or transferred,

v.___ Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

(d) The State also assures the following additional requirements are met:

i.__ The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;

ii. __ The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PCP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

iii. __ The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO/PIHP/PAHP.

(e) **_X_** The MCO/PIHP/PAHP does not cover emergency services.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PIHP/PAHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

(a)__ Enrollees are informed that family planning services will not be restricted under the waiver.

(b)__ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PIHP/PAHP will be required to reimburse non-network family planning services

ii.___ 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 non-network providers

iii.___The State will pay for all family planning services, provided by both network as well as non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) _**X**_ Family planning services are not included under the waiver.

4. **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PIHPs/PAHPs to allow enrollees to self-refer (i.e. access without prior authorization)under the following circumstances or to the following services:

(a) ___ [Required for rural exception to choice]

- The service or type of provider is not available in the plan;
- for up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
- MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.

(b) ___ [Required if women's routine` and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)

(c) _**X**_ Other: (please identify)

Each PIHP has an integrated crisis system, which is accessible 24 hours/7days a week with responses, which are from individuals, rather than recorded messages. The intent is to facilitate efficient and effective mental health crisis diversion and

resolution; to resolve crises in the least restrictive manner possible, including: crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services. These services are available throughout the PIHP, including for American Indians living on or off Indian reservations.

Phone systems must continue to have toll free numbers to ensure access to crisis services, including people who may not have the funds to utilize a public pay phone. If these numbers are not toll free but accept collect charges it must be stated so in the public telephone directory. Services for non-English speaking and hearing impaired enrollees must also be in place.

While crisis response services from PIHPs are covered within the scope of the managed care system, enrollees access to crisis response is unrestricted, without establishing medical necessity for the first contact and without reference to the enrollee's ongoing service coverage under a particular RSN. PIHPs triage with local hospitals to reduce unnecessary utilization of emergency rooms through the working agreements with local evaluation and treatment facilities, which are a necessary qualification of PIHPs. The agreements assure that enrollees who request mental health services inappropriately from emergency rooms are directed to the crisis response system. The agreements also establish how people served in emergency rooms may be referred for Designated Mental Health Professional evaluation for possible involuntary treatment. Emergency room visits not resulting in admission are not covered by this waiver, but as part of the fee-for-service program in MAA. Inpatient services for enrollees admitted through the emergency room are covered provided the designated professional person for the consumer(s) county of residence has conducted a pre-admission certification and conditions of medical necessity are met.

5. _X_ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PIHP/PAHP to track, coordinate, and monitor services to which an enrollee can self-refer:

PIHPs are required to report through the MHD/CIS system crisis services MHD calls out access to care standards with regards to transition from crisis service to routine service. For those consumers already seen by the CMHA, WAC requires access to the consumer's individual service plan 24/7. Additionally, crisis phone services must be available to Limited English Speaking People. The crisis system is also mandated to be accessible for American Indian's living on the reservation. The crisis system is an integral piece of the system and is monitored by the MHD and the PIHPs routinely.

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any

time if he or she desires access to FQHC services. The MCO/PIHP/PAHP is not required to provide FQHC services to the enrollee during the enrollment period.

(b) X The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP/PAHP 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 he or she selected. In any event, 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 with a participating FQHC:

Currently there are FQHCs contracting for mental health services in the public mental health system and will continue participating in the waiver system if they so choose. The PIHPs are required to contract with at least one FQHC in their service area if the FQHC requests. The FQHC is accessed the same as any other CMHA in the RSN service area.

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

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) X The State requires MCOs/PIHPs/PAHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

Washington State has had an approved EPSDT Plan since 1992. Children covered under EPSDT receive the same mental health services as other children. However, given the same clinical need, the child referred through EPSDT screening will receive the first appointment. The plan includes preventive screening and cross-system team planning. This team planning also includes the child and their family. In the mental health system, in the early 90s it was projected that there would be a large influx of children to the system and a special EPSDT flag was established in the data dictionary. While this increase was true of some

of our sister agencies, it was found that the mental health system was already seeing these children. We still require a data flag for children referred to mental health through EPSDT or for those children in the mental health system that are referred to the physical health care programs for a check-up per the periodicity schedule, to the dentist or to substance abuse. We do not however, limit admission to the system to only children referred under EPSDT. Any child meeting the medically necessary definition for mental health services is served.

One initial requirement contained in our original EPSDT implementation that continues today is correspondence and follow-up with physicians or other referral sources for children with EPSDT screens. The Community mental health agencies continue to notify the physician or other referral source when they have seen a child referred and provides information on what service(s) will be offered. This follow-up activity was found to be one of the most influential and helpful activities to increase communication between physical and mental health care for these children. This correspondence loop has also provided for better access to physical health care for the children who are seen initially in the mental health system.

The PIHPs are required to submit the data as they would for any child being served according to the requirements of the data dictionary attached as Attachment C.VI.b. There is simply a data flag if the child is referred in through an EPSDT screen. Of the 43,946 children served in the outpatient mental health system during January 2004-December 2004, there were 13,336 unduplicated consumers flagged as being referred to mental health services through an EPSDT screen. This may be an under reporting of the actual numbers. This is a mandatory data field and when it is submitted unfilled or not 'Yes' or 'No', the EPSDT value is defaulted is no.

(b)__ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) __ Immunizations are covered under this waiver. Please list the

State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d)__ Immunizations are covered under this waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)_X_ Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

The requirement for those individual community teams including the child for the development of service planning for 10% of the children defined in the state's EPSDT plan as level II also requires participation by the cross-system providers. This process includes those who know the child best including the teacher whenever possible to address IEP and other requirements. There is also a requirement in the WAC 388-865-0425 with regards to Individual Service Planning that there be connection to the IFSP.

(f)_X_Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PIHP/PAHP. Please describe.

If a child is being seen by the mental health system or comes through the doors of the mental health system as their first access point, and in need of other health services such as a well child check per the periodicity schedule or the child is in need of dental or substance abuse counseling they are referred to the proper provider of care. Mental Health PIHPs do not provide that type of care. There is a well established referral process between mental health and physical health that in a recent survey by the state was acknowledged by both professions and making a difference in the working relationship of the two system with regards to the holistic care of children.

Section B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residences of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Timely Access Standards

Upcoming Waiver Period -- Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients' normal means of transportation, for MCO/PIHP/PAHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6._X_ Mental Health (please describe your standard):

While it is the belief that consumers should be seen in the place of their choice for community support services, the state recognizes that at times they must travel to community support services. When this occurs the following standards are in place:

- ✓ in rural areas a 30 minute drive time
- ✓ in large rural areas a 90 minute drive time
- ✓ in urban areas, accessible by public transportation. The total trip including transfers shall not be scheduled to exceed 90 minutes each way

The exceptions to these standards identified in the contract are if a consumer chooses to seek services from a community mental health agency that is farther than the drive time or there are hazardous road conditions, road construction, traffic congestion, public transportation shortages, ferry or bus delay etc.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

b. **Appointment Scheduling** (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6._X_ Mental Health (please describe your standard):

Enrollees can access medically necessary mental health services upon request that do not exceed the access standards below. A request for services is defined as a point in time when services are sought or applied for through a telephone call, referral, walk-in, or written request for services. Urgent and Emergent medically necessary mental health services (e.g. crisis services, stabilization services) may be accessed without intake evaluations and/or other screening and assessment processes.

The determination of eligibility for authorization to service shall be based on the Access to Care standards. Authorization shall not take more than fourteen calendar days, unless the enrollee or the CMHA requests an extension. An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA. The PIHP must have 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 mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes

An intake assessment is initiated within 10 working days of the request for services.

Routine mental health services are offered to occur within 14 calendar days of a determination of eligibility. An extension is possible upon request by the enrollee. A total of 28 calendar days from request for services to first routine appointment will be the normal time period expected.

Emergent mental health services occur within 2 hours of the request for services from

any source.

Urgent care occurs within 24 hours of the request for services from any source.

The following are the contract definitions:

<u>Emergent Care:</u> service provided for a person that, if not provided, would likely result in the need crisis intervention or for hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

<u>Urgent Care</u>: To be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

<u>Routine Care:</u> means non-emergent and non-urgent services provided to individuals authorized to receive services as defined in the Access to Care Standards. Routine Care is designed to alleviate symptoms, to stabilize, sustain, and facilitate progress toward mental health.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Urgent care (please describe your standard):

10.___Other providers (please describe your standard):

c. **In-Office Waiting Times:** The State has established standards for in-office waiting times for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.<u>_X_</u> Mental Health (please describe your standard):

For those services that do occur in the office the wait time for a consumer should be minimal. There are times when it may be necessary and acceptable for a consumer to wait however, a consumer should not have to wait for over an hour beyond the scheduled appointment time.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.__ Other providers (please describe your standard):

II. Access and Availability Monitoring: Enrollee access to care will be monitored by the State, as part of each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

Previous Waiver Period

a._X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint; item B.II Upcoming Waiver Period, 9/23/99 Waiver Renewal Preprint].

The EQRO report was sent to CMS, Region X, in March 2005. The next report will be sent in March 2006.

Upcoming Waiver Period -- Check below any of the following (a-o) that the State will also utilize to monitor access: ***Monitoring will take place using the three mandatory EQR protocols to the extent these issues are covered in the protocols***

a._X_ Measurement of access to services during and after a MCO/PIHP/PAHP's regular office hours to assure 24 hour accessibility, 7 days a week *to mental health crisis services and the applicable state plan modalities (*e.g., PCPs' 24-hour accessibility will be monitored through random calls to ~~PCPs~~ *CMHA* during regular and after office hours)

b._X_ Determination of enrollee knowledge on the use of managed care programs *through involvement with the Office of Consumer Affairs, the Roundtable, through SAFE Washington, the MHPAC .*

c._X_ Ensure that services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner.

d.___ Review of access to emergency or family planning services without prior authorization

e._X_ Review of denials of referral requests

f.___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g._X_ Periodic enrollee ~~experience~~ *MHSIP* surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. ~~Corrective actions taken on deficiencies found are also planned.~~ *Individual RSNs will be compared against their own results and not statewide. They are expected to maintain or improve their results.*

h.___ Measurement of enrollee requests for disenrollment from a MCO/PIHP/PAHP due to access issues

i._X_ Tracking of ~~complaints/~~grievances concerning access issues *through the MHD established reporting process through the contract.*

j.___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k.___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. During monitoring, the State will look for the following indications of access problems.

1.__ Long waiting periods to obtain services from a PCP.
2.__ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3.__ Enrollee confusion about how to obtain services not covered under the waiver.
4.__ Lack of access to services after PCP's regular office hours.
5.___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6.__ Lack of access to emergency or family planning services.
7.__ Frequent recipient requests to change a specific PCP.
8.__ Other indications (please describe):

m.__ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n._X_ Monitoring the ~~provider~~ *CMHA* network showing that there will be providers within the distance/travel times standards *per the availability standards described.*

The PIHP must ensure that when enrollees must travel to service sites, they are accessible per the following standards: 1) in rural areas, service sites are within a 30-minute commute time; 2) in large rural geographic areas service sites are accessible within a 90-minute commute time; 3) in urban areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90 minutes each way;

Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) to psychiatric inpatient services; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).

o.__ The incentives, sanctions, and enforcement related to the access and availability standards above.

p.___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a._X_ [Required] MCO/PIHP/PAHP Capacity Standards. The State ensured that the number of providers under the waiver remained adequate to assure access to all services covered under the contract. Please describe the results of this monitoring.

The PIHP contracts with licensed CMHAs for the provision of mental health services. The MHD is the licensor of CMHA and also certifies inpatient beds for involuntary treatment. The number of CMHAs providing services has remained fairly consistent throughout the waiver since 1993. There have been some mergers or sales in the outpatient system but this has not reduced overall capacity. The MHD has licensed five new CMHAs over the course of the last waiver renewal period.

Since the PIHP serves a specific geographic area, the MHD requires assurances from each PIHP that they will guarantee a sufficient number of service sites, both in and out of facility, to assure enrollees have convenient access to service locations as expressed in the availability standards. In addition, under the rehabilitation services options, most services, especially crisis services, are provided out of the facility (e.g., enrollee's residence or in other community settings that are comfortable to the enrollee).

The PIHP will continue to provide inpatient service through community psychiatric inpatient hospitals and will purchase service capacity for adults and children to ensure that services are as close to the enrollee's community as possible so long as it is clinically indicated. The contract with the PIHP stipulates that resource management of acute inpatient care shall be performed under the general oversight of a physician. A physician must review any denial of a request for voluntary inpatient authorization.

The state (MAA) contracts with hospitals that are licensed and willing to provide inpatient psychiatric care. The overall long-term impact of the loss of community psychiatric inpatient hospital beds is a national trend and continues to be difficult to predict. The MHD and the PIHPs are carefully watching capacity. Nonetheless, existing community inpatient psychiatric hospital providers are in very tenuous financial situations, often with little support from their corporate structures.

The state will allow the PIHPs to submit a regional plan for direct contracting with psychiatric hospital providers. Any contract between a PIHP and local hospital must contain the provision of collaboration for emergency admissions to non-contracted hospitals and the transfer of enrollees to contracted hospitals. The state allows exceptions to this, if the transfer would cause harm to the enrollee, or there is no psychiatric hospital unit within reasonable travel time of the residence of the immediate family member who helps with the personal needs of the enrollee. Each PIHP needs to ensure that Medicaid enrollees who have other insurance but have exhausted their benefits will receive continuity of care.

Any PIHP that develops a direct psychiatric hospital contract network will be required to develop a plan that ensures hospitals and physicians will be provided orientation to the prepaid inpatient health plan. All contracts between a PIHP and community hospital will have a grievance procedure for enrollees, which will be made available to enrollees. If a PIHP develops a direct contract network, the state will require them to show that they have a capacity (combined in-network and out-of network providers) of at least 110% of their actual utilization for the prior year. The plan must be submitted to the MHD 90 days in advance for approval.

b._NA [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate. Please describe the results of this monitoring. *Mandatory enrollment.*

Upcoming Waiver Period -- Please describe the capacity standards for the upcoming two year period.

a. MCO/PIHP/PAHP Capacity Standards

1.___ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2.___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

3.**_X_** [Required] The State ensures that the number of ~~providers~~ *CMHAs* under the waiver is adequate to assure access to all services covered under the contract. Please describe how the State will ensure that provider capacity will be adequate.

By contract, the PIHPs must ensure the adequate capacity to serve the entire Medicaid population in their service area that has a medically necessary need for mental health services in the public mental health system. The PIHPs are responsible for the resource and utilization management of the system. The PIHPs are required in contract to submit changes that result in

reduced capacity to the MHD prior to the change. There has been a net increase in new agencies over this period. The MHD monitors grievance and satisfaction as elements of capacity.

b. PCP Capacity Standards

1.___ The State has set capacity standards for PCPs within the MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):

i.___ PCP to enrollee ratio
ii.___ Maximum PCP capacity
iii.__ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans

2._**X**_ The State ensures adequate geographic distribution of ~~PCP~~s *MHCPs* within ~~MCO~~/PIHPs~~/PAHPs~~. Please explain.

The RSNs must assure adequate capacity to serve the Medicaid population.

3.___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

Based on the definition of PCP, mental health does not qualify.

c. Specialist Capacity Standards

1.___ The State has set capacity standards for specialty services. Please explain.

Mental health services are a specialty service. Services must be provided by or under the supervision of a mental health professional. WAC has additional requirements for mental health services for Children, Ethnic Minority, Geriatric and Disability Mental Health Specialists as described in 388-865-0150 and 388-865-405(5). By contract, the PIHP must comply with WAC and have the capacity and staff to meet the needs of the population.

2.___ The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

IV. Capacity Monitoring

Previous Waiver Period

a._X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PIHP/PAHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint; item B.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

The MHD continues to monitor the number of licensed CMHAs, grievance and fair hearing data and issues identified on the MHSIP satisfaction survey with regards to access, quality and appropriateness.

There are approximately 132 licensed and certified CMHA contracting with the RSNs. This is an increase from the last waiver renewal. The number is approximated because of multiple locations of various providers. For example, Compass Health alone has 37 locations. The monitoring of grievance concerning capacity issues shows that there are no significant numbers of incidents either statewide or in a particular part of the state that require intervention by MHD. During this current waiver period the MHSIP survey focused on children and adults and the results show for FY05, the overall rating of access to services was 70.6%, and varied by PIHP from a low of 60.3% to a high of 85.7%. The overall rating of quality of services was 86.4%, and varied by PIHP from a low of 77% to a high of 100%. The overall rating of participation in treatment was 69.5%, and varied by PIHP from a high of 81.6% to a low of 50%. These results are similar to statewide results found in the Fiscal Year 2001 and 2003 surveys.

Upcoming Waiver Period --
Please indicate which of the following activities the State employs:

a._X_ Periodic comparison of the number and types of Medicaid ~~providers~~ CMHA before and after the waiver.

b.___ Measurement of referral rates to specialists.

c.___ Provider-to-enrollee ratios

d.___ Periodic MCO/PIHP/PAHP reports on provider network

e.___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f._X_ Tracking of ~~complaints/~~grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k._X_ Consumer ~~Experience~~ *MHSIP* Survey, including persons with special needs,

l.__ Other (Please explain):

V. Coordination and Continuity of Care Standards

Upcoming Waiver Period -- Check any of the following that the State requires of the MCO/PIHP/PAHP:

a.____ Primary Care and Coordination

(i)__ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees.

See (iv)

(ii)__ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services.

See (iv)

(iii)___ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP.

See (iv)

(iv)__ [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(iv)_X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the primary care requirements of 42 CFR 438.208. Please explain.

As a mental health carve out, our system does not meet the definition of Primary Care Provider. The PIHPs are required to provide continuity of care between inpatient and outpatient mental health services and are also required to refer Medicaid consumers to their physical health care provider when they note they are in need of a physical. The PIHPs are also required to work in partnership with other Medicaid managed care programs within the state when appropriate and asked.

b.___ Additional services for enrollees with special health care needs.

(i)_X_ [Required] 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.

Per CMS decision, all persons covered meet the definition of CMS as a person with special health care needs. In this carve out program those persons served have a serious mental illness or a serious emotional disturbance.

(ii)_x [Required] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate *mental* 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.

All consumers receive an intake assessment.

(iii)_x [Required] Treatment Plans. For enrollees with special health care needs who need a course of *mental health* treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. **_X_** ~~Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee~~ *Developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable*
2. __ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
3. **_X_** In accord with any applicable *WAC*. ~~State quality assurance and utilization review standards~~.

(iv)**_X_** [Required] Direct access to *mental health professionals* ~~specialists~~. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

This is a mental health carve-out waiver therefore all services are specialty services. PIHPs are required to coordinate care with other Medicaid managed care systems (p.59) and with allied social service systems (p63-64).

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

VI. Coordination and Continuity of Care Monitoring

Previous Waiver Period

a._X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint; item B.VI. Upcoming Waiver Period, 1999 Renewal Waiver Preprint.].

The QA & I team through both the onsite contract monitoring of the PIHP and through licensing review monitor that treatment plans are being developed with the participation of the consumer and their natural support system. The team looks for quotes of both the consumer and those that they have identified as being an integral part of their treatment, The MHD requires the plan is required to be written in a language easily understood by consumers therefore the team looks for abbreviations, overly complicate clinical description etc. The team also reviews for coordination of services when required (MHD protocols for children and older adults) and consultation with children, geriatric, ethnic minority and disabled mental health specialists.

Currently the MHSIP survey monitors satisfaction with participation in treatment and treatment planning. Please see the survey results on the web at http://depts.washington.edu/washinst/.

c._X_ [Required for all elements checked in the previous waiver submittal if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PIHP/PAHP providers were educated about how to detect MH/SA problems for both children and adults and where to refer consumers once the problems were identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP/PAHP providers. Please describe how this issue was addressed in the PIHP/PAHP program.

The RSNs work with both Healthy Options providers and other physicians around children, adults, and older adults with regards to mental illness, pharmacy and cross-system care. These contractors and sub-contractors work closely together and do cross-system training on access/referral to services, symptoms, reactions, and integrated planning.

d._**X**_[Required if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees were monitored in this waiver program.

Medication management and medication monitoring is provided through CMHAs. These services include the prescribing and/or administering and reviewing of medications and their side effects. This service is rendered face-to-face by a person licensed to perform such services. Service may be provided in consultation with collateral, primary

therapists, and/or case managers, but includes only minimal psychotherapy. Medication monitoring is face to face cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service.

QA & I staff as part of the case record review look at medication prescription to see that the medications are prescribed by a qualified physician or an ARNP with prescriptive authority and that they are reviewed/monitored on at least a three month cycle. Monitoring would/could include side effects, lab tests, etc. The team also notes in the case record review the results of medication monitoring and the compliance and positive outcomes noted.

The QA & I team also review medication storage at the CMHA as part of the ADA/federal requirement walk around per WAC 388-865-0458.

Pharmacy services (purchasing) are provided by MAA through a fee-for-service system. For atypical antipsychotics MAA requires the DSM IV diagnosis to be made by a qualified mental health profession and the prescription to be written by, or in consultation with a psychiatrist, neurologist, psychiatric ARNP or pharmacist with prescriptive authority for these drugs. Pharmacists are able to use a provided expedited prior authorization code if the prescription fits the above stated expedited authorization criteria. There are checks and balances in place, including pharmacy audits by the Payment Review Program, to assure that prescriptions match to the proper DSMIV code. If the prescription does not meet the expedited prior authorization criteria, pharmacists are required to call MAA for prior authorization and provide the information for medical necessity of this prescription for a review by the MAA Medical Consultant. Additional reviews are preformed as part of the drug utilization process. An example of one of these reviews is a letter issued to prescribers of patients that had multiple antipsychotic or multiple antidepressant prescriptions to verify the medical necessity of continuing on these prescriptions.

Additionally, MAA monitors prescription drugs in various ways:

- Edits and audits are put into the payment system to prevent inappropriate payments
- Post-payment reviews look for billing errors such as: Package Size, Rounding, and Quantity Errors
- Neural net models are utilized to compare providers to their Washington peers enabling us to detect aberrant billing patterns
- Reports and queries are available in the Decision Support System (DSS) for utilization review
- On-site audits are conducted by MAA auditing staff

Upcoming Waiver Period -- Please describe how standards for continuity and

coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination and continuity standards checked above in Item B.V?

This will continue to be monitored through the use of the required EQRO protocols and according to those schedules and by the QA & I on-site contract monitoring.

b. Specify below which providers are excluded from the capitated waiver and how the State explicitly requires the MCO/PIHP/PAHP to coordinate health care services with them:

1.___ Mental Health Providers (please describe how the State ensures coordination exists):

2._X_ Substance Abuse Providers (please describe how the State ensures coordination exists):

3._X_ Local Health Departments (please describe how the State ensures coordination exists):

4._X_ Dental Providers (please describe how the State ensures coordination exists):

5._X_ Transportation Providers (please describe how the State ensures coordination exists):

6._X_ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7._X_ Developmental Disabilities (please describe how the State ensures coordination exists):

8._X_ Title V Providers (please describe how the State ensures coordination exists):

9.___ Women, Infants and Children (WIC) program

10._X_ Indian Health Services providers

11.__ FQHCs and RHCs not included in the program's networks

12.__ Other (please describe):

The RSNs have working partnerships with a variety of other community services. They have the responsibility for many shared consumers. The RSNs and CMHAs are required to participate in multi-system coordination efforts whenever possible. They are required

to refer consumers to alternate or additional services that the CMHA or the consumer's individual Mental Health Care Provider believes the consumer needs to complete or aid in the recovery process. However, they must use caution and care not to violate confidentiality of mental health care and the consumer's right to privacy. The RSNs have developed and are implementing service protocols with regards to children and older adults. The MHD as part of the umbrella agency of DSHS also monitors coordination efforts through meetings with other divisions within the department, through our work with the Indian Policy Advisory Committee, and stakeholder meetings with both the Office of the Superintendent of Public Instruction and e the Department of Health. As described in the background section of this renewal the MHD and the RSNs host and participate on many stakeholder groups to gather input on improvement for the system. That in its self is an excellent monitoring tool.

RSN contracts have the following coordination requirements:

1.4.7. The Contractor must participate in the coordination of mental health services with other systems of care when clinically indicated. The Contractor must:

1.4.7.1. Maintain MHD approved service protocols developed with the DSHS Children's Administration and DSHS Aging and Disability Services Administration. Submit updates for each protocol to MHD for approval by January 30, 2006.

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

1.4.7.3. Formalize the relationship between the Contractor and Healthy Option plans in the service area through a Memorandum of Understanding.

1.4.7.4. Formalize the relationship between the Contractor and the DSHS Division of Vocational Rehabilitation (DVR) office in the service area. The Contractor must develop and implement formal working Agreements, for the coordination of care, with local offices of DVR. The Contractor must submit completed working Agreements to MHD within 90 days of execution of this Agreement.

1.4.7.5. Comply with published directives from MHD when the Contractor or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by MHD) regarding service or cost responsibilities.

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCOs, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint, item C.1 Upcoming Waiver Period, 1999 Waver Renewal Preprint].

The EQRO report was submitted in March 2005.

b.___ Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires.

a._X_ [Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).

The state has a CMS approved quality strategy in place.

b._X_ [Required] The State ~~must~~ obtain*ed* the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

c._X_ [Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

d._X_ [Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning ~~8/14/03~~*3/25/04*.

1. Please specify the name of the entity:

~~2~~*1b.* The entity type is:

(a)__ A Peer Review Organization (PRO).
(b)__ A private accreditation organization approved by CMS.
(c)__ A PRO-like entity approved by CMS.

2. Please describe the scope of work for the External Quality Review Organization (EQRO):

The following language is direct from the EQRO contract:

1) Conduct PIHP reviews using required Center for Medicaid and Medicare Services (CMS) protocol entitled "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations (42 CFR Part 438, Subparts A through J) for all protocol areas in which the PIHP scored less than a (3) three. The Contractor shall collect PIHP data using this protocol and is expected to use additional processes as necessary to prepare for and conduct these reviews in order to effectively support and conclude the compliance determination activities. 2) Validate PIHP Performance Measures using required CMS protocol (42 CFR Part 438, Subparts A - J)

– validate data systems and data reported by the PIHP to the MHD. Validate MHD's methodology for calculating Performance Indicators. Provide recommendations about data systems and performance indicators. Conduct performance measure validation onsite review as part of the compliance onsite review.

- validate both the data and the methods used to calculate the subset measures. The subset measures that will be used in the review process are:

1. Medicaid Penetration rates – for community outpatient services by age group.

2. Medicaid Utilization rates – for community outpatient services by age group.

3. Consumer Survey Results – from the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey and the Youth and Family Services Survey.

2) Validate PIHP Performance Improvement Projects using CMS protocol (42 CFR Part 438, Subparts A through J) - validate MHD's and the PIHP's methodology for calculating Performance Indicators, conduct PIHP review, validate quality improvement activities, and provide recommendations for future quality improvement activities/projects.

3) Conduct a complete Encounter Validation using CMS protocol – Validating Encounter Data – A protocol for use in Conducting Medicaid External Quality

Review Activities.

- MHD to provide APS a data extract ASAP for 1 fiscal yrs worth of encounters (July 1 2004 – June 30 2005)

- APS will analyze these encounters and determine which providers within each PIHP require further review.

- APS will request copies of medical records from the identified providers and will cover the cost of copying and postage.

- APS will review the medical records at APS offices in Olympia for documentation of reported encounters.

- APS will conduct follow-up reviews of any issues discovered during on-sites reviews

- Document findings and incorporate into the PIHPcomplete report

4) Analyze PIHP compliance with the CMS protocols, trends, and provide recommendations. In addition to providing written PIHP compliance determination reports, the Contractor shall provide an on-site briefing for leadership of each PIHP at the conclusion of compliance determination activities.

5) Provide a Report about each PIHP's performance to the PIHP and to the MHD.

Compile the reviewers' notes, evaluation tools, and copies of documentation in the Contractor's Washington State office.
Synthesize the results into a preliminary report, addressing PIHP compliance, trends and recommendations.
The preliminary report will be examined by the reviewers for accuracy.
Following the initial review, provide a preliminary report and debriefing to the leadership of each PIHP after completing its report of findings.
Participate in debriefing to be conducted at the PIHP's offices.
Discuss any inaccuracies and resolve outstanding issues.

6) Complete a Technical Report – the report must be reviewed by MHD and submitted to CMS by March 25, 2006. The report shall describe the manner in which data from all activities conducted in accordance with 42 CFR 438.358 are collected and aggregated. Data related to the quality, timeliness, and access to care collected from PIHPs will be analyzed and synthesized into an annual report.

The report shall include the following:

a. An assessment of each PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to mental health care services furnished to Medicaid recipients.

b. Recommendations for improving the quality of mental health care services furnished by each PIHP;

c. Methodologically comparative information about all PIHPs.

d. An assessment of the extent each PIHP has the capacity to address recommendations for quality improvement made by the EQRO.

e. The report must address the following for each activity (in accordance with CFR 438.358): objectives; technical methods of data collection and analysis; description of data obtained; and conclusions drawn from the data. The report shall be submitted to and approved by MHD and CMS.

f. Documents reviewed and incorporated into the technical report shall include:

1. Findings from MHD and EQRO validation of PIHP performance improvement projects.

2. Findings from EQRO assessment of PIHPs to determine compliance with Medicaid Managed Care regulations (42 CFR Part 438, Subparts A through J). These reviews are conducted yearly, with an every three (3) year comprehensive assessment.

3. MHD PIHP performance measures.

4. Other information as relevant to the activities listed in this RFP.

7) Provide reporting and educational approaches to keep MHD, PIHP and key stakeholders informed and involved in project activities throughout the length of the Contract. Survey each PIHP regarding their satisfaction with the assistance provided by the Contractor, accumulate survey responses after technical assistance provided to each PIHP and report successes as well as opportunities for improvement to PIHP onsite review team, and discuss survey results within onsite review team and incorporate feedback in preparation for next technical assistance to be provided to the PIHPs. In addition, the contractor shall provide :

1. Quarterly status reports to the MHD, due one month following the end of the quarter.

2. Introducing projects and keeping key stakeholders informed of progress towards completing project tasks.

3. Providing technical assistance and training to people responsible for obtaining project data.

4. Planning and organizing two (2) meetings with PIHPs each year.
For community psychiatric inpatient hospital services the MHD will work with the MAA to assure the information is captured.

e. __X__ The State includes required internal quality assessment and performance improvement (QAPI) standards in its contracts with MCOs and PIHPs.

f.__ The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1.__ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.

2.__X__ [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

3.__X__ Conducts monitoring activities using (check all that apply):

(a)__X__ State Medicaid agency personnel

(b)__ Other State government personnel (please specify):

(c)__~~X~~__ A non-State agency contractor (please specify):

4.__ Other (please specify):

g.NA for PIHP[Required] The State has established intermediate sanctions that it may impose.

h. __X__ [Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement .

II. Access Standards

Coverage and Authorization of Services

Previous Waiver Period

a.__X__ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal

Preprint].

PIHPs are required to provide services comparable in scope and intensity to the state plan rehabilitation services and community inpatient services for adults and children. PIHPs must also ensure system capacity to provide a full range of mental health services to meet the individual enrollee's needs in a way that provides for seamless coordination and continuity of mental health services creating the least amount of disruption in the enrollee's life and supports recovery and reintegration to their community.

The MHD monitors services in a variety of ways. In addition to the annual on-site monitoring activities of the EQRO, & the MHD contract monitoring, there are the meetings with stakeholders as described, additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys.

The EQRO report was submitted to CMSRegion X in March 2005. The report can be accessed at: http://www1.dshs.wa.gov/Mentalhealth/publications.shtml .

EQRO on site visits to RSNs for the current year are taking place in December 2005.

The Performance Indicator report may be found at http://www1.dshs.wa.gov/mentalhealth

The child and adult satisfaction survey have been conducted. Results and comparisons of consumer surveys may be found at http://depts.washington.edu/washinst .

Upcoming Waiver Period -- Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs,PIHPs, and PAHPs:

a.__X__ [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

b.__X__ [Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

c.__X__ [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

"Medical necessity" or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to: 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

d. __X__ [Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

e. __X__ [Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

f. __X__ [Required] Require that the MCO,PIHP, and PAHP consult with the requesting ~~provider~~ *CMHA*-when appropriate.

g. __X__ [Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

h. __X__ [Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

i. __X__ [Required] Require that the MCO,PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee *or the MHCP* requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest. *Mental health access standards are more stringent than this requirement. They are 2 hours for emergent, 24 hours for urgent and 14 days for routine.*

j.___ Other (please describe):

III. Structure and Operation Standards

Provider Selection

Previous Waiver Period

[Required for all related items checked in previous waiver request] Please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

The MHD has not received any notice from a community mental health agency with regards to selection over this waiver period. Again, the MHD licenses the CMHAs.

Upcoming Waiver Period

The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes or procedures that the State includes in its policy

a._X_ [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of providers.

b._X_ [Required] Each MCO, PIHP, PAHP must not discriminate against particular ~~providers~~ *CMHAs* that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.

c.___ Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups 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.

d.___ Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1.___ Initial credentialing

2.___ Performance indicators, including those obtained through the following (check all that apply):

(a)__ The quality assessment and performance improvement program

(b)__ The utilization management system

(c)__ The grievance system

(d)__ Enrollee satisfaction surveys

(e)__ Other MCO/PIHP/PAHP activities as specified by the State.

e.___ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State ___________________________

f.___ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g.___ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h.___ Other (please describe):

IV. Subcontractual Relationships and Delegation

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver period, 1999 Waiver Renewal Preprint].

The EQRO reviewed samples of model subcontracts from each of the 14 RSNs and found them to generally be in compliance with requirements. If the samples were found to contain deficiencies the RSNs were required to submit corrective action plans and amend their subcontracts.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

a.___ Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2.___ All model subcontracts and addendum

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b._X_ [Required] Monitors to ensure that MCOs,PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

c._X_ [Required] Requires agreements to be in writing and to specify the delegated activities.

d._X_ [Required] Requires agreements to specify reporting requirements.

e._X_ [Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

f._X_ [Required] Ensures that MCOs,PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.

g._X_ [Required] Monitors to ensures that MCOs,PIHPs, and PAHPs formally review the entity's performance *on an annual basis.* ~~according to a periodic schedule established by the State.~~

h._X_ [Required] Ensures that MCOs,PIHPs, and PAHPs retain the right to approve, suspend or terminate any ~~provider~~ *CMHA* when they delegate selection of providers to another entity.

i._X_ [Required] Requires MCOs,PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

j.___ Other (please explain):

V. Measurement and Improvement Standards

Practice Guidelines

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of

compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

The EQRO has monitored this and has found that adopting and implementing practice guidelines is new to the majority of the PIHPs. A number of the practice guidelines adopted were developed locally and did not appear to be based on valid and reliable clinical evidence. Often Network Providers were unaware that practice guidelines had been adopted, and if they did know, they couldn't remember what they were.

Few PIHPs were able to demonstrate that the practice guidelines were being applied to utilization management decisions, enrollee education, type of service and fit and other pertinent decisions and interventions. As the behavioral health field is being asked to prove it is accountable and offers a valuable service for the expended resources, there is a lot more work being done to research and identify practice guidelines and evidence-based practices and their value to service recipients and the field. It is the recommendation of the EQRO that the PIHPs utilize the available research and research based practice guidelines when adopting guidelines for their regional system of care. It is also recommended to include enrollees and Network Providers in the development and decision making processes related to the adoption of practice guidelines. Once the practice guidelines are officially adopted, it would be helpful for the PIHPs to provide a formal, in-depth training for the Provider Networks and interested consumers with particular focus on the application of the practice guidelines.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

a._X_ [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of *mental* health care professionals in the ~~particular~~ *mental health* field.

b._X_ [Required] Guidelines consider the needs of the MCO's,PIHP's or PAHP's enrollees *with regards to mental health.*

c._X_[Required] Guidelines are developed in consultation with contracting *mental* health professionals.

d._X_ [Required] Guidelines are reviewed and updated periodically.

e._X_ [Required] Guidelines are disseminated to all affected ~~providers~~ *CMHAs*, and, upon request to enrollees and potnetial enrollees.

f._X_ [Required] *When selected by the PIHP* Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g.___ Other (please explain):

Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a. __X__ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renwal Preprint]. Please break down monitoring results by subpopulations if available.

The QAPIs are included in the EQRO report submitted to CMS in March 2005.

b.___ The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

The state and the PIHP have been participating with SAMHSA, CMHS, as part of the 16-state performance indicator project and now as part of the data infrastructure grant. The report may be found at http://www1.dshs.wa.gov/mentalhealth .

Upcoming Waiver Period- The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

a. __X__ [Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:

Our review will occur through the use of the three mandated EQR protocols and was submitted in March 2005..

1. __X__ The MCO's and PIHP's performance *indicators* ~~on the standard measures~~ on which it is required to report.

Through the participation of the state with SAMHSA on the data infrastructure grant there will be data shown for each of the 14 RSNs. As it is with the states and the data infrastructure grant, the RSNs will be measured against them selves and not against each other.

2.___ The results of each MCO's and PIHP's performance improvement projects.

b. ___Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have:

1.___ A policy making body which oversees the QAPI

2.___ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3.___ Active participation by providers and consumers

4.___ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

c.__X_[Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms:

The PIHP must have documented procedures to identify at the RSN level over and under utilization; to require CMHA to have their own procedures that the RSNs monitor at time of contract compliance visits, to further investigate the PIHP-level instances, and to monitor the utilization over time of those cases so identified.

Additionally, they may use IS data to identify over and underutilizers, then discuss the specific cases with the CMHA. Some RSNs as a quality management tool, may review 1% or 500 charts whichever is the least to detect both over and under utilization of service.

d. **_X_** [Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs**.** Please describe these mechanisms:

Please see our response to special health care needs above.

e._X__[Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

Please see Attachment C.VI.b. - Data Dictionary and the Performance Indicator Report which may be found on the MHD's website which is http://www1.dshs.wa.gov/mentalhealth .

Performance Improvement Projects

f.__X_ [Required] Each MCO and PIHP must conduct performance improvement

projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on *mental* health outcomes and enrollee satisfaction.

g.___ Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

h._X_[Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

The PIHPs and the MHD have agreed upon one clinical and one non-clinical QAPI to be statewide for each RSN. The clinical indicator is the consumer participation in treatment, the non-clinical is data quality. In addition each PIHP must add two additional Performance Improvement Projects this year. The EQRO is reviewing and evaluating the PIPs, MHD will review the reports from the EQRO and determine if the PIPs meet the state standards.

Clinical Indicator:

The recommendation from the PI workgroup for the statewide clinical indicator was a focus on Consumer Participation in Treatment. This indicator was chosen for several reasons. Washington's mental health system values consumer voice and participation and this indicator examines how well these values are being translated into practice. Data is collected through a yearly survey and Quality Assurance and Improvement (QA/I) reviews. These two tools can be easily tapped and used for a performance indicator.

In fact, the MHD has done much work with the PI workgroup in previous years to create a report based on the consumer surveys. Because this information is already collected on an annual basis data is available to establish baselines. Finally, this indicator was chosen because it is a treatment practice that should be unaffected by the anticipated changes that will take place due to the Access to Care Standards and minimum eligibility criteria.

Measuring Participation in Treatment: Two data sources will be used to monitor this indicator. (1) The MHSIP consumer surveys and (2) data collected during the annual Quality Assurance & Improvement reviews.

The MHSIP family/youth survey and the MHSIP adult survey are collected

biannually. The family/youth survey was conducted in 2000 and 2002 and the adult survey was conducted in 2001. Surveys are conducted on a random sample of mental health consumers stratified by RSN and age. The Washington Institute conducts the MHSIP surveys via telephone using a CATI.

The QA/I teams visit RSNs annually to conduct quality and licensing reviews. One of the areas examined by the review teams is consumer participation in treatment. Evidence of consumer participation in treatment involves finding direct quotes from consumers contained in medical records or charts.

Monitoring & Implementing Improvement Strategies: The MHD will develop a strategy to convey the survey results and the QA/I findings to each individual RSN. The RSNs will be responsible for developing and implementing a quality improvement plan to improve or sustain the indicator and make this plan available to the MHD for review and monitoring.

Non-Clinical Indicator:

The PI workgroup decided that data quality would be the focus of the non-clinical indicator. The Information System Data Evaluation Committee(ISDEC), because of their knowledge and expertise in this area, were asked to define this indicator. They focused on the new Health Insurance Portability and Accountability Act (HIPAA) standards for data transmission. Focusing on the 837P data standards the group agreed on one indicator that will be reported by all RSNs as their non-clinical indicator:

Measuring Data Transmission: RSNs will monitor the transmission of 837P data on an on-going basis. RSNs will record the percentage of transactions which meet the 60-day reporting window set forth in contract. During the last review of this PIP, none of the RSNs had met the target.
Monitoring & Implementing Improvement Strategies: All RSNs are required to develop and implemen a quality improvement plan to improve or sustain the indicator and make this plan available to the MHD for review and monitoring

i.__X__ [Required] Each MCO and PIHP must measure performance using objective quality indicators.

j. __X__[Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

k.__X__ [Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

l.__X__ Each MCO and PIHP must correct significant systemic problems that come to its attention through ~~internal surveillance~~ *monitoring*, complaints, or other mechanisms.

m.__X__ MCOs or PIHPs are allowed to collaborate with one another on projects, subject

to the approval of the State Medicaid agency.

n.___ Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

o.___ Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

p.___ Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

q.___ Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

r.___ Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.

s.___ Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

t.___ Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

u.___ Other (please describe):

VI. Mental Health Information Systems

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The RSNs now submit data within acceptable standards. The Information System Data and Evaluation Committee (ISDEC) continues to meet and facilitate data quality improvements. The MHD and the RSNs are now HIPAA compliant and use standard transactions and national code sets for encounter reporting.

The MHD and CMS have reached a decision on the issues of CPT/HCPC codes and our state plan service definitions. As far back as 2002, the MHD recognized that there were issues and discrepancies between the state plan definitions and

allowable CPT/HCPC codes. This has lead to a situation where two of our state plan definitions can not be coded using existing CPT/HCPC coding. Those services continue to be counted as "other."

We have continued to worked with SAMHSA, CMHS, and others to map CPT/HCPC onto our state plan services. Currently, under the new state agency organizational structure, the MHD is working with coding experts from the Medical Assistance section to look at identifying standard coding for all behavioral health services paid for by the state.

MHD is committed to continuing this work to make the definitions more clearly reflect the services provided and we appreciate the assistance of CMS staff in this process.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs and PIHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

a._X_ [Required] Provide information on

1.__X_Utilization,
2._X_ Grievances and appeals, *not through the IS system but through other reporting*
3.___ Disenrollment for reasons other than loss of Medicaid eligibility.

b._X_[Required] Collect data on enrollee and ~~provider~~ *CMHA* characteristics as specified by the State. . *The Data dictionary is available on request.*

c._X_ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply):

Please see the data dictionary above

1._X_ [Required] Recording sufficient patient data to identify the ~~provider~~ *CMHA* who delivered services to Medicaid enrollees

2._X_ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by ~~providers~~ *CMHAs* and subcontractors

3._X_ [Required] Verifying the accuracy and timeliness of data

4._X_[Required] Screening data for completeness, logic and consistency

5._X_ [Required] Collecting service information in standardized formats to the extent feasible and appropriate

6.___ Other (please describe):

d.___ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1.___ Health services (please specify frequency and provide a description of the data and/or content of the reports)

2.___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3.___ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4.___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e.___ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

f._X_ Ensure that information and data received from providers are accurate, timely and complete.

g._X_ Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

h.___ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.___ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.

j.___ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e. report cards). Please describe.

k.___ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

l.___ Other (please describe):

Section D. 1915(B) COST-EFFECTIVENESS PREPRINT AND INSTRUCTIONS

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of “with waiver” and “without waiver” costs. Instead, States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

The 1915(b) Cost-Effectiveness Preprint and Instructions are divided into 4 major sections:

Section I. Definitions and Terminology
Section II. General Principles of the Cost-Effectiveness Test
Section III. Instructions for Appendices
Section IV. State Completion Section

In addition there are seven Appendices:

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

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska’s actual experience or program structure.*

In addition, technical assistance is available through each State’s CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

Actual Waiver Service Cost + Actual Waiver Administration Cost<= Projected Waiver Cost

I. Definitions and Terminology

The following terms will be used throughout this document and are defined below:

For Initial Waivers:

Historical Period

- BY = Base Year

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Conversion Waivers *(existing waivers which will "convert" from the former "with and without waiver" cost effectiveness test to the newcost effectiveness test described in these instructions)*:

Historical Period for first time a State completes the new cost effectiveness test

- BY = Base Year – CMS prefers 7/1/2001 – 6/30/2002

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

For Renewal Waivers:

Retrospective Waiver Period

- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

Form CMS-64: *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (MBES - formerly known as the HCFA-64) submitted by States as an accounting statement under Title XIX and Title XXI of the Social Security Act. The *Form CMS 64* is completed according to the reporting instructions in the State Medicaid Manual, Section 2500. Additional technical assistance is available through each State's CMS Regional Office. Each Regional Office will have a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests. In general, CMS-64 data is recorded based on the date that a payment was made to a provider.

Form CMS-64 Summary and CMS-64.9:

The *Form CMS-64 Summary* is an accounting of all expenditures for Medical Assistance **services and administration** for both MAP (CMS-64.9) and ADM (CMS-64.10) under Medicaid Title XIX and Title XXI Medicaid Expansion Groups including waiver expenditures. The Summary Sheet is generated from all worksheets entered by the State in support of each line item (including prior period adjustments). The *CMS-64.9* reports current expenditures for Medical Assistance **services** under the non-waiver programs.

Form CMS-64.10: The *Form CMS-64.10* is an accounting of **administrative** expenditures in Medicaid Title XIX for non-waiver programs.

Form CMS-64.21U: The *Form CMS-64.21U* is an accounting of **service and administrative** expenditures for the State Medicaid Expansion portion of the Children's Health Insurance Program (SCHIP) Title XXI. This form reports expenditures for children covered under 1905(U)(2) and (U)(3) of the Social Security Act.

Form CMS-64 F:
The *CMS-64 F Form* recaps all *CMS-64.21 Medicaid Expansion Forms* and Medicaid *CMS 64.9 Forms*. The *CMS-64 F Form* is summarized in the *CMS-64 Summary Form*. The *CMS-64 F* describes the source of the data on each line of the *CMS-64 Summary*. An example follows:
CMS-64 Summary, Line 6 MAP = $100
CMS-64 F, Line 6 MAP, *Form CMS-64.9* = $80
CMS-64F, Line 6 MAP, *Form CMS-64.21* = $20

Form CMS-64.9 Waiver: Same as the *Form CMS-64.9* except the *Form CMS-64.9 Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver program. The State will provide separate *CMS-64.9 Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.9 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.9 Waiver form* for expenditures that are not included on other *64.9 Waiver forms*. The *CMS-64.9 Waiver forms* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.9 Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.9 Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.9 Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.9 Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instruction section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the following Standard 1915(b) Waiver coding system:

- State Code: This will be the State's two-digit identifier (e.g., CA, FL, PA);
- Two digit waiver number;
- Followed by the two-digit waiver renewal number; and
- Followed by the two-digit consecutive waiver year.

Please work with your RO if you need guidance identifying this number. *Example: The Iowa Plan reporting for a waiver renewed on July 1, 2001 would use: IA07.R02.05. The Iowa Plan is Iowa's seventh waiver. It was renewed for the second time on July 1, 2001. If the first year of their waiver began July 1, 1997, the waiver year beginning July 1, 2001 would be 05.*

State Code	IA
Two-digit waiver number	07
Two-digit waiver renewal number	02
Two-digit consecutive waiver year	05

Form CMS-64.9P Waiver: Same as the *CMS-64.9 Waiver* except reporting a prior period adjustment.

Form CMS-64.10 Waiver: Same as the *Form CMS-64.10* except the *Form CMS-64.10 Waiver* reports Administration costs only for the population and services covered by the State's 1915(b) waiver program. The State will provide separate *CMS-64.10 Waiver forms* for each 1915(b) waiver program. The State must report administrative costs attributable to each waiver program on separate *CMS-64.10 Waiver forms*. Administrative costs that are applicable to more than one waiver program must be allocated to the respective *CMS-64.10 Waiver forms* based on a method approved by CMS (e.g., allocation based on caseload or Medical Assistance payments). Therefore, the *CMS-64.10 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If the State has specific questions regarding this requirement, please contact your State's RO. To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system. *Note: States should document their cost allocation methodology for administration costs between waivers in D.IV.G.*

Form CMS-64.10P Waiver: Same as the *CMS-64.10 Waiver* except reporting a prior period adjustment.

Form CMS-64.21U Waiver: Same as the *Form CMS-64.21U* except the *Form CMS-64.21U Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver programs. Cost Effectiveness requirements apply only to Medicaid Expansion SCHIP populations under 1905(U)(2) and (U)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(U)(2) and (U)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program. The State will provide separate *CMS-64.21U Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.21U Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.21U Waiver form* for expenditures that are not included on other *64.21U Waiver forms*. The *CMS-64.21U Waiver sheets* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.21U Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.21U Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only

beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.21U Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.21U Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instructions section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system.

Form CMS-64.21UP Waiver: Same as the *CMS-64.21U Waiver* except reporting a prior period adjustment.

Schedule D: Schedule D is a report of waiver expenditures by waiver year for a given waiver period that is generated within the Medicaid Statement of Expenditures for the Medical Assistance Program (MBES) when selected by an MBES user from the reports menu. The State will submit a Schedule D for the previous waiver period with each renewal submission.

Base Year: In an Initial Waiver (i.e., first submission of a new program's cost-effectiveness data), CMS requires all States to create a BY which can be used to project total expenditures for the projected waiver period (P1 and P2). The BY must be the most recent year that has already concluded. The State must justify the use of any other year as the base year. All expenditures in the BY will be verified by the RO. The BY expenditure and enrollment data should be the actual experience specific to the population covered by the waiver. The maximum time period between a BY and P1 should be five years. CMS recommends that States use the first day of a Federal quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Base Year for Conversion Waivers: In Conversion Renewal Waivers (i.e., existing waivers which will comply with these cost-effectiveness instructions ***for the first time under the new BBA regulations only***), CMS will require all States to create a BY which can be used to project total expenditures for the projected waiver periods (P1 and P2). If possible, the BY should be a year which has already concluded and where no additional payments can be recorded. All expenditures in the BY will be verified by the RO. CMS prefers that states use 7/1/2001 – 6/30/2002 as their BY because it was prior to the announcement of the new test and would not allow states to increase costs after the announcement that there would be no retrospective review for the conversion renewal period. That base year is also complete and allows states to begin analysis in order to submit their waivers in a timely manner. If the State would like, CMS will negotiate a BY that has already been concluded other than 7/1/2001 – 6/30/2002. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to adding into waiver cost projections.*

Caseload: The total number of individuals enrolled on a waiver at any given time is its caseload.

Because cost-effectiveness is calculated on a PMPM, the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload. The standard measurement for caseload is member months.

Case mix: The payments and the PMPM costs of a waiver program are affected by the distribution of the caseload among different reporting categories (MEGs in a 1915(b) waiver). The relative distribution of a member months among MEGs is referred to as membership mix or "case mix". Anytime a State has a MEG with greater than average cost and a caseload growing at a faster rate than less expensive MEGs, the overall weighted average should account for casemix changes or there will be a false impression of the waiver not being cost-effective. *For example, in a State with 100 enrolled members, MEG 1 has a PMPM cost of $3,000 and has 25% of the member months (25 member months) in the base year. MEG 2 has a PMPM cost of $300 and has 75% of the member months (75 member months) in the base year. The overall weighted PMPM for BY with the base year casemix would be:*

$$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975 \qquad \frac{\text{BY PMPM x BY MM}}{\text{BY MM}} = \text{BY PMPM With Casemix for BY}$$

The State projects that the casemix and costs will remain the same in the future (P1). However, if in P1, the program's casemix changes so that MEG 1 has 30% of the member months and MEG 2 has 70% of the member months in P1. The overall weighted PMPM for P1 with the P1 casemix would be:

$$\frac{(\$3000 \times 30) + (\$300 \times 70)}{100} = \$1{,}110 \qquad \frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}} = \text{P1 PMPM With Casemix for P1}$$

In this case, because MEG 1 has a high cost, a relative distribution change from MEG2 to MEG 1 artificially inflates the PMPM if the State does not account for the changes in the casemix.

The overall weighted PMPM for P1 with Casemix for BY

$$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975 \qquad \frac{\text{P1 PMPM x BY MM}}{\text{BY MM}} = \text{P1 PMPM With Casemix for BY}$$

Throughout this document, CMS has explained when to account for casemix changes and how to calculate those calculations. In determining whether to renew the waiver, States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. However, for the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one which accounts for casemix changes (to monitor for PMPM waiver cost-effectiveness) and another which does not account for casemix changes (to monitor for overall growth in CMS-64 expenditures). These calculations are projected in D6 and explained in the instructions and Technical Assistance Guide.

Medicaid Eligibility Group (MEG) - A MEG is a population reporting category usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Each State will have at least one Title XIX MEG for a Medicaid 1915(b) waiver. If the State includes MCHIP populations under 1905(U)(2) and/or (U)(3) in the 1915(b) waiver, then the State will also have at least one Title XXI MEG. Each MEG's costs will be reported on a separate 64.9 Waiver Form (64.21U Waiver Form if the MEG is for an MCHIP population). States are held accountable for member month distribution changes within MEGs, but not between MEGs. In cases where significantly different costs exist between different populations, the State should consider separate MEGs to account for the likelihood of a change in the proportion of the enrollees being served in any single reporting

group. The State should recognize the impact on cost trends of the increase in the proportion of membership, which would be associated with the higher cost group when determining cost-effectiveness. The State may want to consider a more complex reporting structure, which would attempt to recognize high-cost groups separately from low-cost groups. It is in a State's interest to group populations with similar costs and similar caseload growth together. *For example, a State has a program with 100 member months - 25% of which cost $3,000 and 75% of which cost $300. The State can choose to have a single MEG with a PMPM cost of $975 or two MEGS with a weighted PMPM of $975. If the state has a distribution shift between the two population groups so that there are relatively more expensive persons costing $3,000, the State will be held accountable for that redistribution effect if it has only one MEG and will not be held accountable if the State has two MEGS. The weighted-average PMPM Casemix for BY for the single MEG is $1,110. The weighted-average PMPM Casemix for BY for two MEGs is $975.*

One MEG

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) *100*	*= 975*	*($3000 x 30) + ($300 x 70)* *100*	= $1,110
BY PMPM x BY MM BY MM	=BY PMPM With Casemix for BY	P1 PMPM x P1 MM BY MM	=P1 PMPM With Casemix for BY

Two MEGs

Base Year PMPM Casemix BY		P1 PMPM Casemix BY	
($3000 x 25) + ($300 x 75) *100*	*= 975*	*($3000 x 25) + ($300 x 75)* *100*	= 975
BY PMPM x BY MM BY MM	=BY PMPM With Casemix for BY	(P1 PMPM x BY MM) + (P1 PMPM x BY MM) BY MM	=P1 PMPM With Casemix for BY

Adjustments: Each State creates budget projections in a slightly different manner than other states. To address this, CMS has identified the most common adjustments states make to base year data (in initial and conversion waivers) and R2 data (in renewal waivers). The State must document each adjustment made, what is meant by each adjustment in the State Completion Section, how that adjustment does not duplicate another adjustment made, and how each adjustment was calculated. For example, in the State Completion section, the State is asked to document the State Plan Services Trend Adjustment. The State Plan Services Trend Adjustment reflects the expected PMPM cost and utilization increases (e.g., service prices, practice patterns, and technical innovation) in the managed care program from R2 (BY for initial/conversion waivers) to the end of the waiver (P2). Trend adjustments may be State Plan service-specific. Adjustments are typically expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states may calculate a combined trend rate. Because the trend is expressed on a PMPM basis, the State should explain what is accounted for in the trend adjustment (i.e., cost and utilization increases). Any trend should not be duplicated in the State's

adjustments for programmatic/policy/pricing adjustments. For example, a Legislative price increase would be explained and reflected in the programmatic/policy/pricing adjustment not under the State Plan Services Trend Adjustment. The State should document how the adjustments are unique and separate.

Trend: Growth in spending from one year to the next year. Growth may be due to cost and utilization increases. Growth due to external forces such as Legislative change or program/contract change should be documented separately under adjustments that include more than trend. If only a trend adjustment is allowed, then growth due to external forces is not allowed without a separate waiver amendment documenting additional savings. In this preprint, all adjustments are made on a PMPM basis. For the sake of simplicity, whenever trend appears alone it refers to a PMPM increase in the cost.

Comprehensive Waiver Criteria: When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test: 1) Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority; 2) Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc); or 3) State Plan services were procured using sole source procurement.

Expedited Test: States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. To be able to use the Expedited Test for a particular waiver, a State would need to:
Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria (see above) OR Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver, which meets the Comprehensive Waiver Criteria except for the transportation and dental waivers specifically exempted.

Projections in Renewal Waivers: In Renewal Waivers, State will use its actual experience R1 and R2 data to project its P1 and P2 expenditures from the endpoint of the previous waiver of R2. In each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

Projected Waiver Period: P1 and P2 are projections of the Medicaid waiver program expenditures for the future two-year period for the population covered by the waiver.

Retrospective Waiver Period: R1 and R2 are the actual Medicaid waiver program expenditures in the historical two-year period for the population covered by the waiver. These R1 and R2 costs are compared to the P1 and P2 projections from the previous waiver submission. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual*

administration and service costs must be verified by the RO prior to developing waiver cost projections.

1915(b)(3) service: An additional service for beneficiaries approved under the waiver paid for out of waiver savings. The service is not in the State's approved State Plan. Capitated 1915(b)(3) services must have actuarially sound rates based only on approved 1915(b)(3) services and their administration subject to RO prior approval.

Acronyms used in this section

ADM - Administration
AI/AN – American Indian/Alaskan Native
BBA – Balanced Budget Act of 1997
BY – Base Year
CAP - cost allocation plan amendment
CE – Cost Effectiveness
CMS – Centers for Medicare and Medicaid Services
Co. - County
CSHCN – Children with Special Health Care Needs
CY – Calendar Year
DRG - Diagnostic Related Group
DSH - Disproportionate Share Hospital Payments
EQR – External Quality Review
FFP – Federal Financial Participation
FMAP – Federal Medical Assistance Participation
MAP – Medical Assistance Program or services
FFS – fee-for-service
FQHC – Federally Qualified Health Center
FY- Fiscal Year
GME – Graduate Medical Education
HIO – Health Insuring Organization
MBES - Medicaid Statement of Expenditures for the Medical Assistance Program
MCO – Managed Care Organization
MCHIP – Medicaid-Expansion Children's Health Insurance Program
MEG – Medicaid Eligibility Group
MMIS – Medicaid Management Information System
P1 – Prospective Year 1
P2 – Prospective Year 2
PAHP - Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Manager
PIHP – Prepaid Inpatient Health Plan
PMPM – Per Member Per Month
RHC – Rural Health Center
SPA – State Plan Amendment
PRO – Peer Review Organization
Q1 – Quarter 1
Q4 – Quarter 4
Q5 – Quarter 5

R1 – Retrospective Year 1
R2 – Retrospective Year 2
RO – Regional Office
SCHIP – State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System
Title XIX – Medicaid
Title XXI - State Children's Health Insurance Program
TPL – Third Party Liability
UPL – Upper Payment Limit

II. General Principles of the Cost-Effectiveness Test

1. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. In order to grant a 1915(b) waiver, a State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. The State will document program expenditures on the CMS- 64 for the same two-year period for the population covered by the waiver. In other words, a State initially projects spending and documents on an on-going basis that the actual expenditures are at or below the projected amount.

2. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that it was cost-effective during the retrospective two-year period and must create waiver cost projections that will be used to determine cost-effectiveness for the prospective two-year period. The cost-effectiveness test is applied to the combined two-year waiver period, not to each individual waiver year or portion of a year.

3. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. States no longer need to demonstrate that "with waiver" costs are lower than "without waiver" costs. Instead, States must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. Retrospectively, the State will document that program expenditures were less than or equal to these projections. As with all elements of 1915(b) waivers, States may amend their cost-effectiveness projections if the waiver program changes or if additional information documents that the projections are inaccurate and should be modified accordingly.

4. Each Initial Waiver submission will include a State's projected expenditures for the upcoming two year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2).

5. For each Renewal Waiver submission, a State will demonstrate cost-effectiveness for the retrospective waiver period by showing that the actual expenditures for retrospective years one and two (R1 and R2) did not exceed what the State had projected it would spend (P1 and P2) for the same two-year period on a per member per month (PMPM) basis for the population covered by the waiver. In other words, a State must compare what it had initially projected it would spend to what it actually spent over the waiver period and show that the actual expenditures came in at or under the projected amount. *Please note that for Conversion Waivers, CMS will not require a retrospective cost-effectiveness test. The State is only allowed a single Conversion Waiver, the first time the State submits a waiver renewal after the announcement of this new method.*

6. In order to project expenditures for the prospective waiver period, a State must use the actual historical expenditures from its base year (for an initial or conversion waiver) or from the past waiver period (R1 & R2 for a renewal waiver) as the basis for its cost

effectiveness projection, adjusting for future changes in trend (including utilization and cost increases), and other adjustments acceptable to CMS. By always using actual historical expenditures from the most recent waiver period as the basis for the projection, the cost-effectiveness test for a waiver program will be "rebased" upon each renewal. *Note: this applies to both capitated and FFS services within 1915(b) waivers. The State must document that actual costs claimed on the CMS-64 were used to document the Actual Waiver Cost in Appendix D3.*

7. All 1915(b) waivers will use this cost-effectiveness test, regardless of the type of waiver program or the delivery system under the waiver.

8. All Medicaid Medical Assistance program expenditures (fee-for-service and capitated services) related to the services covered by the waiver will be reported for the population enrolled in the waiver. Because waiver providers can affect the costs of services not directly included in the waiver, CMS is requiring that States include **all Medicaid Medical Assistance program expenditures related to the population and services covered by the waiver, not just those services under the waiver,** in developing their cost-effectiveness calculations. See the detailed instructions below for additional guidance.

9. CMS will evaluate cost-effectiveness based on all Medicaid expenditures for waiver enrollees impacted by the waiver, even those expenditures that are outside the capitation rate or do not require a PCCM referral. These services are generally referred to as "wrap-around" or "carved-out" services and may include such services as pharmacy or school-based services that may be paid on a fee-for-service (FFS) basis for the population covered by the waiver. See the detailed instructions below for additional guidance. Additional guidance is also available in the technical assistance guide for cost-effectiveness. Each State will need to work with CMS to determine whether or not services that are not explicitly under the waiver should be included in the cost-effectiveness calculations.

10. Because all affected Medicaid Medical Assistance program expenditures for waiver enrollees will be counted in cost-effectiveness calculations, there will essentially be no difference in the extent to which services are impacted by either a PCCM system or capitated program cost-effectiveness test. Initial waivers with both PCCM and capitated delivery systems may need to make some specific adjustments in PCCM system expenditures as noted in the **State Completion Section D.IV.I Special Note for Capitated and PCCM combined initial waivers**.

11. State administrative costs associated with the program and population enrolled in the waiver will also be reported. Administrative costs include, but are not limited to, State expenditures such as enrollment broker contracts, contract administration, enrollee information and outreach, State utilization review and quality assurance activities, State hotline and member services costs, the cost of an Independent Assessment, External Quality Review (EQR), actuary contracts, and administrative cost allocation (salaries).

12. All administrative and service costs should be calculated on a per member/per month basis. States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. States should have total PMPM actual waiver expenditures for the two-year period equal to or less than the corresponding total PMPM projected waiver expenditures for that same period. For the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one examining aggregate projected spending compared to the aggregate CMS-64 totals and the second examining PMPM spending compared to PMPM projections. *See the instructions for Appendix D6 for the explanation of the two calculations and detailed instructions on how to calculate and monitor each test.* **For the ultimate decision of cost-effectiveness (i.e. the decision to renew each waiver), the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.**

13. Cost-effectiveness will be calculated on a total PMPM basis, which is comprised of both service and administration costs.

14. CMS will track and evaluate waiver cost effectiveness using expenditure data as reported on the CMS-64 and will be measured in total computable dollars (Federal and State share). All waiver expenditures will be reported on the CMS-64.9 Waiver, CMS-64.21U Waiver, or CMS-64.10 Waiver forms on a quarterly basis. (Data from the CMS-64.21U Waiver form will be used if the State enrolls its Medicaid-expansion SCHIP population in the waiver.)

15. All expenditures are based on the CMS-64 Waiver forms, which are based on date of payment, not date of service. States will itemize all expenditures for the population covered under the Waiver into each of the main service categories in the CMS-64 Waiver forms. These forms have been cleared by OMB (No. 0938-0067). The *Form CMS-64.9 Waiver* for Medical Assistance payments includes the major categories of service: inpatient hospital services, physician services, dental, clinic, MCO capitation, etc. Administrative expenditures will be reported on the CMS-64.10 Waiver form accordingly. *Note: please ensure that the State's projections for initial, conversion, and renewal waivers are projections for date of payment as well.*

16. States with multiple 1915(b), 1915(c), and 1115 waivers that have overlapping waiver populations will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the *CMS-64 Summary*.

17. All actual expenditures reported and used as the basis for a cost effectiveness projection must be verified by the RO.

18. The expenditures and enrollment numbers for voluntary populations (i.e., populations that can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in

State's 1915(b) waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers. If the State wants to include voluntary populations in the waiver, then the expenditures and enrollment numbers for that population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in their waiver are required to submit a written explanation of how selection bias will be addressed in the waiver cost-effectiveness calculations. *Note: This principle does not change the historic practice of requiring States to include the experience of a voluntary MCO population in a mandatory PCCM waiver if a beneficiary can be auto-assigned to one of the delivery systems.*

19. States with 1932 managed care SPA programs with an overlapping 1915(b) waiver will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the CMS-64 Summary.

20. Incentive payments will be included in the cost effectiveness test. Incentives included in capitated rates are already constrained by the Medicaid managed care regulation at §438.6(c) to 105% of the capitated rates based on State Plan services. If there are any incentives in FFS/PCCM, those payments must be applied under the cost-effectiveness test. For example, if PCCM providers are given incentives for reducing utilization, the incentives are limited to the savings of State Plan service costs under the waiver. This policy creates a restraint on the FFS/PCCM incentive costs. States should ensure that all incentives are reported in renewal Actual Waiver Costs in **Appendix D3**.

21. 1915(b)(3) waiver services will be included in the cost effectiveness test. In general, States cannot spend more on 1915(b)(3) services than they would save on State Plan services.

22. Cost Effectiveness requirements apply to Medicaid Expansion SCHIP populations under 1905(U)(2) and (U)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(U)(2) and (U)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program in the Medicaid delivery system.

23. Comprehensive Waiver Criteria - When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test:
    - Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority,
    - Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc), or
    - State Plan services were procured using sole source procurement (Sole source procurement means non-open, non-competitive procurement not meeting the

requirements at 45 CFR 74.43). States must utilize the Comprehensive Cost Effectiveness Test to apply for and renew 1915(b) waivers that award services contracts using procurement methods meeting the criteria in 45 CFR 74.44 (e). Most competitive procurements resulting in a single contractor are not considered sole-source procurement under the 45 CFR 74.44(e) criteria. The State should verify the regulatory requirements and use the expedited test only if all expedited criteria are met.

24. Expedited Test – CMS is proposing a waiver-by-waiver test to expedite the processing of certain renewal waivers. States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. States will simply submit *Schedule D* and the most recent 8 quarters of waiver forms from MBES to CMS along with projections for the upcoming waiver period (**Appendix D1, D2.S, D2.A, D4, D5, and D6**). For additional guidance, please see the Cost-effectiveness Technical Assistance Manual. To be able to use the Expedited Test for a particular waiver, a State would need to:
    - Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria OR
    - Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver which meets the Comprehensive Waiver Criteria except for transportation and dental waivers as noted below.

25. Cost-effectiveness for waivers of only transportation services or dental pre-paid ambulatory health plans (PAHPs) are processed under the expedited test if the transportation or dental waiver alone meets the expedited criteria. In this instance, States should not consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. If enrollees in a transportation or dental waiver are also enrolled in pre-paid inpatient health plans (PIHPs), MCOs, or PCCMs under separate waivers or separate SPA authority, the costs associated with dental or transportation services should not be included in any other 1915(b) waiver cost effectiveness test.

III. Instructions for Appendices

Step-by-Step Instructions for Calculating Cost-Effectiveness

Appendix D1 – Member Months

Document member months in the Base Year (BY)/ Retrospective Waiver Period (R1 and R2) and estimate projected member months in the upcoming period (P1 and P2) on a quarterly basis. Actual enrollment data for the retrospective waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed for RO monitoring on a quarterly basis. States will not be held accountable for caseload changes. This data is also useful in assessing future enrollment changes in the waiver.
States must document the number of member months in the waiver for the retrospective waiver period (R1 and R2) for renewal waivers and in the base year (BY) for initial and conversion waivers

For initial or conversion waivers, document member months from the Base Year (BY). For renewal waivers, document member months from Retrospective Waiver Period (R1 and R2). Categorize all enrollees into Medicaid Eligibility Groups (MEG). A MEG is usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Please note that States will use these same MEGs to report expenditures on the CMS 64.9 Waiver, CMS 64.10 Waiver, and/or CMS 64.21U Waiver.

CMS recommends that the State analyze their capitated program's rate cell categories to support the development of the Medicaid Eligibility Group (MEG) detail within the cost-effectiveness analysis. A MEG is a reporting group collapsing rate cell categories into groups that the State anticipates will have similar inflation and utilization trends, as well as by program structure (eligibility, geography, service delivery, etc). Every MEG created will mean a separate CMS 69.9 Waiver form, etc and results in additional quarterly expenditure reports to CMS. Selecting the right number of MEGs is a very important step. *See the MEG definition above for further guidance.* States should use the 64.9 and 64.21 waiver form population categories for any renewals. *For example, Nebraska chose to divide their single waiver into four MEGs. Nebraska has Medicaid Expansion SCHIP populations in their 1915(b) waiver, which automatically means that 2 MEGs are necessary (one for TXIX and one for MCHIP). In addition, Nebraska chose to separate costs for Special Needs children's populations and AI/AN populations from all other enrollees because of the structure of their program and differential caseload trends that they anticipate. During the waiver, Nebraska will report waiver costs on two separate 64.9 Waiver forms ((Medicaid (No CSHCN or AI/AN – PIHP only), and Medicaid (CSHCN or AI/AN– MCO/PIHP/PCCM) and two separate 64.21U Waiver forms (MCHIP (No CSHCN or AI/AN– PIHP only), MCHIP (CSHCN or AI/AN – MCO/PIHP/PCCM)). In Nebraska's renewal they would have a MEG for each of the four populations).*

Step 1. List the Medicaid Eligibility Groups (MEGs) for the waiver. List the base year eligible member months by MEG. Please list the MEGs for the population to be enrolled in the waiver program. The number and distribution of MEGs will vary by State. For renewals, if the State used different **MEGs** in R1 and R2 than in P1 and P2, please create separate tables for the two waiver periods (the state will be held accountable for caseload changes between MEGs in this

instance). The base year for an initial waiver should be the same as the FFS data used to create the PMPM Actual Waiver Costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted in the Appendix and explained in the State Completion Section of the Preprint.

Step 2. Project by quarter, the number of member months by MEG for the population that will participate in the waiver program for the future waiver period (P1 and P2). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in R1 and R2. List the quarterly member/eligible months projected in each MEG by quarter. States who are phasing in managed care programs or populations may choose to have quarterly estimates that are not equal (i.e., P1 Q1 reflects a different enrollment than P1 Q4).

Step 3. Total the member/eligible months for each quarter and year. Calculate the annual and quarterly rate of increase/decrease in member months over the projected period. Explain the rate of increase/decrease in the State Completion section.

Appendix D2.S - Services in Waiver Cost
Document the services included in the waiver cost-effectiveness analysis.

Step 1. List each State Plan service and 1915(b)(3) service under the waiver and indicate whether or not the service is:

- State Plan approved;
- A 1915(b)(3) service;
- A service that is included in a capitation rate; paid to either MCOs, PIHPs, or PAHPs, (whichever is applicable);
- A service that is not a waiver service but is impacted by the MCOs, PIHPS, or PAHPs (whichever is applicable);
- a service that is included in the PCCM FFS reimbursement.

The chart in **Appendix D2.S** should be modified to reflect each State's actual waiver program. States should indicate which services are provided under each MEG, if the benefit package varies by MEG. Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

Step 2. Please note any proposed changes in services on Appendix D2.S with a *. *See the Nebraska example for illustration purposes.*

Step 3. List the State Plan Services included in the Actual Waiver costs (only State Plan Service costs may be included in an initial waiver's Actual Waiver Costs). Please also list the 1915(b)(3) non-State Plan services proposed in the initial waiver and any 1915(b)(3) services included in the Actual Waiver costs for a conversion or renewal waiver. For an MCO/PIHP/PAHP waiver, include services under the capitated rates, as well as services

provided to managed care enrollees on a fee-for-service wraparound basis (note each). For a PCCM program, include services requiring a referral, as well as services provided to waiver enrollees on a wraparound basis. Please add lines and specify as needed.

(Column B Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver

-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services

-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column C Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column D Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column E Explanation) MCO Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO. If a 1915(b)(3) service in an MCO is capitated, please mark this column.

(Column F Explanation) Fee-for-Service Reimbursement impacted by MCO: Check this column if the service is not the responsibility of the MCO, but the MCO or its contracted providers can affect the utilization, referral or spending for that service. *For example, if the MCO is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription*. Do not mark services NOT impacted by the MCO and not included in the cost-effectiveness analysis. *For example, a State would not include Optometrist screening exams in states where vision services are not capitated, a PCP referral is not required for payment, and PCP do not refer or affect patient access to vision screening examinations.*

(Column G Explanation) PCCM Fee-for-Service Reimbursement: Check this column if this service will be included in the waiver and will require a referral/prior authorization or if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the waiver. *Please see the*

Inclusion of Services in Cost-Effectiveness Test *chart below for guidance.*

(Column H Explanation) PIHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PIHP. If a 1915(b)(3) service is capitated in a PIHP, please mark this column.

(Column I Explanation) Fee-for-Service Reimbursement impacted by PIHP: Check this column if the service is not the responsibility of the PIHP, but is impacted by it. For example, if the PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PIHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PIHP. *Please see the* ***Inclusion of Services in Cost-Effectiveness Test*** *chart below for guidance.*

(Column J Explanation) PAHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the PAHP. If a 1915(b)(3) service is capitated in a PAHP, please mark this column. *Note: the Nebraska example did not include a PAHP and so did not include this column.*

(Column K Explanation) Fee-for-Service Reimbursement impacted by PAHP: Check this column if the service is not the responsibility of the PAHP, but is impacted by it. For example, if the PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PAHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PAHP. *Please see the* ***Inclusion of Services in Cost-Effectiveness Test*** *chart below for guidance. Note: the Nebraska example does not include a PAHP delivery system and so did not include this column.*

Note: Columns C and D are mutually exclusive. Columns E and F are mutually exclusive for the MCO program. Columns H and I are mutually exclusive for the PIHP program. Columns J and K are mutually exclusive for the PAHP program. Each service should have a mark in columns C or D. If the State has more than one MEG, Appendix D2 should reflect what services are included in each MEG.

Chart: Inclusion of Services in Cost-Effectiveness Test
Note: All references to the single CMS 64.9 Waiver form refer to a 1915(b) waiver that does not include any SCHIP Medicaid expansion populations. If a 1915(b) includes an SCHIP Medicaid expansion population, the State would also complete a CMS 64.21U Waiver form for the applicable SCHIP Medicaid expansion population. In addition, the State can always choose to divide its data into **MEGs** for additional reporting categories. Services included in other 1915(b) waivers should be excluded and not counted under two separate 1915(b) cost-effectiveness tests. Services in 1915(c) waivers should only be included for concurrent 1915(b)/1915(c) waivers. Services for 1115 Demonstration waivers should only be included if the 1915(b) population is being used as an impacted population in the 1115 Demonstration. *See the Technical Assistance Manual for additional information.*

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
Medicaid beneficiary is enrolled only in 1915(b) for transportation	PAHP	Transportation only	Transportation	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for dental	PAHP	Dental only	Dental	All other Medicaid services
Medicaid beneficiary is enrolled only in 1915(b) for mental health – remaining services are FFS or under 1932 SPA *(examples: rural Nebraska and Iowa)*	PIHP	Mental Health and Substance Abuse are under waiver. Pharmacy, rehabilitation services, and inpatient psychiatric services for individuals under age 21 are fee-for-service.	All Mental Health, Substance Abuse, Pharmacy, Inpatient psychiatric services for individuals under age 21, and Rehabilitation services for waiver enrollees are reported on single *CMS-64.9 Waiver form* for the 1915(b) waiver.	All other Medicaid services
Medicaid beneficiary is enrolled in one 1915(b) waiver for mental health and MCO services *(examples: urban Nebraska special needs children)*	PIHP and MCO	All services	All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form*	None.
Medicaid beneficiary is enrolled in 1915(b) for mental health and separate 1915(b) for MCO	PIHP and MCO	All services except pharmacy are in one waiver or the other	The State divides all services for waiver enrollees into two *CMS-64.9 Waiver forms*: one for the mental health 1915(b) and the other for the MCO 1915(b).	None.
Medicaid beneficiary is enrolled in a single1915(b) for mental health and PCCM *(examples:*	PIHP and PCCM	All services except school-based services	All services including school-based services for waiver enrollees are reported on a *CMS-64.9 Waiver form*	None.

Example	Type of Delivery System	Services Under 1915(b) waiver	Services included in Cost Effectiveness Test	Services excluded from Cost Effectiveness Test
urban Nebraska special needs children)				
Medicaid beneficiary is enrolled in 1915(b) PCCM or MCO	PCCM and/or MCO	All services	All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form*	None.

Appendix D2.A Administrative Costs in the Waiver
Document the administrative costs included in the Actual Waiver Cost.

Step 1. Using *CMS-64.10 Waiver Form* line items numbers and titles, document the State's administrative costs in the waiver. **Do not include MCO/PIHP/PAHP/PCCM entity administration costs.** For initial waivers, this will include only fee-for-service costs such as MMIS and SURS costs. For renewal waivers and conversion waivers, the administrative costs will include managed care costs such as enrollment brokers, External Quality Review Organizations, and Independent Assessments. Add lines as necessary to distinguish between multiple contracts on a single line in the CMS-64.10. *Note: PCCM case management fees are not considered State Administrative costs because CMS matches those payments at the FMAP rate and states claim those costs on the CMS-64.9 Waiver form. Services claimed at the FMAP rate should be reported on* ***Appendix D2.S*** *and not reported on* ***Appendix D2.A***.

Step 2. The State should allocate administrative costs between the Fee-for-service and managed care program depending upon the program structure. For example, for an MCO program, the State might allocate the administrative costs in the Administrative Cost Allocation Plan to the MCO program based upon the number of MCO enrollees as a percentage of total Medicaid enrollees. For a mental health carve out enrolling most Medicaid beneficiaries in the State, allocate costs based upon the mental health 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. Explain the cost allocation process in the preprint.

Appendix D3 – Actual Waiver Cost
Document Base Year and Retrospective Waiver Period expenditures (actual expenditures in the BY for initial/conversion waivers and R1 and R2 in renewal waivers). States that are eligible to use the expedited process for certain waivers need not complete Appendix D3; instead, attach the most recent waiver Schedule D. For all other submissions, States should complete **Appendix D3**.

The State must document the total expenditures for the services impacted by the waiver as noted

in **Appendix D2**, not just for the services under the waiver. For an Initial Waiver or Conversion Waiver, the State must document the expenditures used in the BY PMPM. **All expenditures in the BY will be verified by the RO.** For a Renewal Waiver, the State must document the actual expenditures in the retrospective two-year period (R1 and R2) separating administration, 1915(b)(3), FFS incentives, capitated, and fee-for-service State Plan expenditures as noted. **Actual expenditures will be verified by the RO on a quarterly basis by comparing projections to actual expenditures and other routine audit functions.**

The actual expenditures used in the cost-effectiveness calculations should include all Medicaid program expenditures related to the population covered by the waiver, not just those services directly included in the waiver. If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64. Incentives to capitated entities are reflected in **Column D of Appendix D3** of the spreadsheets. Fee-for-service incentives, such as incentives to PCCM providers, are noted separately in **Column G of Appendix D3**. 1915(b)(3) services in the initial waiver will always be zero in **Column H of Appendix D3** of the initial waiver because 1915(b)(3) services are a result of savings under the waiver and cannot exist prior to the waiver.

Actual expenditures are based on the CMS-64 Waiver forms, which are based on date of payment not date of service.

States must separately document actual Medical Assistance service expenditures and actual State administrative costs related to those services. Actual case management fees paid to providers in a PCCM program should be included as service expenditures.

Since a State may be in the process of developing a Renewal Waiver during the second year of the waiver (R2) period (to avoid an extension), the State should project the remaining period of time for which actual expenditures are not yet available for R2 (approximately 6 months). If the State projects any portion of R2, please document those projections and the assumptions made.

Should a State request and be granted one or more 90-day temporary extension(s) for submitting a Renewal Waiver, the following process applies depending on the length of the extension:

- For three or fewer 90-day temporary extensions (a period of less than one year after the expiration of the waiver), the State must demonstrate cost-effectiveness over the original two-year period included in the waiver. In other words, if a waiver considered years CY 2003 and CY 2004 as P1 and P2, respectively, and 2 three-month temporary extensions were obtained, the State would still be required to demonstrate cost-effectiveness for calendar year 2003 and 2004 by comparing actual expenditures (R1 and R2) to the projected expenditures (P1 and P2) for these two years in aggregate. In this scenario, actual expenditures for the entire R2 period may be available to support the Renewal Waiver calculations.
- For four or more temporary extensions (a period of one year or more after the expiration of the waiver), the State must demonstrate cost-effectiveness for the

original two-year period included in the waiver as previously described and in addition demonstrate cost-effectiveness for the one-year extension period (to the extent data is available – in this case CY2005). In this scenario, actual expenditures for the entire R2 period will be available to support the Renewal Waiver calculations, but the extension year may require projecting actual expenditures. The State's extension year will be compared to the expenditure projections as if P2 were 24 months rather than 12 months.

Number of Extensions	Demonstration of Cost-Effectiveness	Example
3 or fewer 90-day temporary extensions	Demonstrate cost-effectiveness for the original two-year period	Waiver CY2003 and CY2004 2 Extensions through 7/1/2005 State CE covers only CY2003 and CY2004
4 or more temporary 90-day extensions	Demonstrate cost-effectiveness for the original two-year period and for each additional one-year extension period	Waiver CY2003 and CY2004 4 Extensions through CY2005 State CE covers CY2003, CY2004, and CY2005

Fee-for-service Institutional UPL Expenditures to include and not include in the cost-effectiveness analyses.

- **Transition amounts should be excluded** from the Cost-Effectiveness test. A transition amount is what the State spent over 100% of the institutional fee-for-service UPL (i.e., the "excess"). The State should isolate the excess amounts to remain in fee-for-service outside of the waiver and include only the amount under 100% of the FFS UPL in the Cost-effectiveness analysis.
- **Supplemental payments at or below 100% of the UPL should be included** in the cost-effectiveness analysis. States that are not transition States may in fact make supplemental payments below or up to the 100% UPL and that money should be included in the cost-effectiveness. The entire amount of the supplemental payment at or below the UPL should be in the 1915(b) analysis.

States should contact their RO for additional State-specific guidance on the inclusion and exclusion of Fee-for-service Institutional UPL payments.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.** The renewal will list the MEGS twice – once for R1 and once for R2. *See the example spreadsheets.*

Step 2. List the BY eligible member months (R1 and R2 member months, if a renewal). *See the example spreadsheets.*

Step 3. List the base year (R1 and R2 if a renewal) aggregate costs by MEG. Actual cost and eligibility data are required for BY (R1 and R2) PMPM computations. Aggregate Capitated Costs are in Column D. Aggregate FFS costs are in Column E. Add D+E to obtain the State Plan total aggregate costs in Column F. List FFS incentives in Column G. In a renewal or conversion waiver, list 1915(b)(3) aggregate costs in Column H. List Administrative costs in Column I. For an initial waiver, these PMPM costs are derived from the State's MMIS database or as noted from the explanation in the State Completion section under **Section D.IV.I.c**. Comprehensive Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D and with additional ad hoc reporting for 1915(b)(3) services and FFS incentive payments. The State must track FFS incentive and 1915(b)(3) payments separately (those costs will not be separately identified on Schedule D). The State must document that State Plan service aggregate costs amounts were reduced by the amount of FFS incentives and 1915(b)(3) costs spent by the State. To calculate the PMPM by MEG for 1915(b)(3) services, the State should divide the cost of 1915(b)(3) service costs by MEG for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for FFS incentives, the State should divide the cost of FFS incentives for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for State Plan Services, the State should divide the cost of State Plan Services from Schedule D (minus FFS incentives and 1915(b)(3) service costs) for R2 and divide by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application. The portion of R2 that is actual should match the Schedule D submitted.*

Step 4. Total the base year capitated costs and fee-for-service costs to derive the total base year costs for services. Add all costs (F, G, H, and I) to obtain total waiver aggregate costs.

Step 5. Divide the base year (BY) costs by the annual BY (divide the R1 costs by the R1 MM or the R2 costs by the R2 MM, if a renewal) member months (MM) to get PMPM base year (R1 or R2) costs**.** In this instance, the State calculates the overall PMPM for BY (the overall PMPM for R1 or the overall PMPM for R2 in a renewal). The State will divide the costs of the program by the caseload for the same year from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program’s caseload at the new distribution level between MEGs for each year of the waiver (R1 and R2). In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

Initial/Conversion	Renewal R1	Renewal R2
BY Costs BY MM	R1 Costs R1 MM	R2 Costs R2 MM
Overall PMPM for BY	Overall PMPM for R1	Overall PMPM for R2

Appendix D4 – Adjustments in the Projection
Document adjustments made to the BY or R1 and R2 to calculate the P1 and P2. The State will mark the adjustments made and document where in Appendix D5 the adjustment can be found. All adjustments are then explained in the State Completion portion of the Preprint.

Waiver Cost Projection Adjustments: On **Appendix D4**, check all adjustments that the State applied to the R1/R2 or BY data. In Column D, note the location of each adjustment in **Appendix D5**. Note: only the adjustments listed may be made. If the State has made another adjustment, the State should obtain CMS approval prior to its use. Complete the attached preprint explanation pages and include attachments as requested. ***Note:*** *(Initial Waiver only) Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- some adjustments to the Waiver Cost Projection in an initial waiver must be made due to a policy decision in the capitated program. Those adjustments are permitted only to the capitated programs and need an offsetting adjustment to the PCCM Waiver Cost Projections in order to make the PCCM costs comparable to the Actual Waiver Costs. Please see the State Completion Section of the initial waiver for further instructions if the State has a combined capitated and PCCM cost-effectiveness analysis.*

Appendix D5 – Waiver Cost Projection
Each time a waiver is renewed, a State must develop a two-year projection of expenditures. States must calculate projected waiver expenditures (P1 and P2) for the upcoming period. Projected waiver expenditures for P1 and P2 should be created using the State's actual historical expenditures (e.g., BY data for an Initial or Conversion Waiver, or R2 data using R1 & R2 experience to develop trends for a Renewal Waiver) for the population covered under the waiver and adjusted for changes in trend (including utilization and cost increases) and other adjustments acceptable to CMS. For example, in an Initial or Conversion Waiver, a State should use its actual BY data to project its P1 and P2 expenditures. In a Renewal Waiver, a State should use its actual experience in R1 and R2 to project trends for its P1 and P2 expenditures from the endpoint of the previous waiver of R2. As a result, in each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2.

Projected waiver expenditures must include all Medicaid expenditures for the population included in the waiver, not just those services directly included in the waiver, calculated on a PMPM basis and including administrative expenses. (For example, a State must include services that are outside of the capitated or PCCM program.) If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64.

In projecting expenditures for the population covered by the waiver, States must use trends that are reflective of the regulation requirements for capitated rates and fee-for-service history for fee-for-service rates. The State must document and explain the creation of its trends in the State

Completion Section of the Preprint. CMS recommends that a State use at least three years of Medicaid historical data to develop trends. States must use the State historical trends for the time periods where actual State experience is available. States must use the prescribed methods (see the State Completion Section) for inflating FFS incentives (no greater than the State Plan trend rate), 1915(b)(3) services (the lower of State Plan service and actual 1915(b)(3) trend rates), and administration (historic Medicaid administration trend rates unless the State is using sole source procurement to procure State Plan services)

States need to make adjustments to the historical data (BY for initial/conversion and R2 for renewals) used in projecting the future P1 and P2 PMPMs to reflect prospective periods. For Renewals, these adjustments represent the impact on the cost of the State's Medicaid program from such things as: State Plan service trend, State Plan programmatic/policy/pricing changes, administrative cost adjustments, 1915(b)(3) service trends, incentives (not in the capitated payment) adjustments, and other. Since States are required to consider the effect of all Medicaid costs for the waiver population, States should consider adjustments that might impact costs for services not directly covered under the waiver (i.e., global changes to the Medicaid program).

1915(b)(3) services must be paid out of savings in the future years (P1 and P2) of the waiver. Under 1915(b)(3) authority, states can offer additional benefits using savings from providing State Plan services more efficiently. The following principles and requirements will be used to evaluate the cost-effectiveness of waiver requests that include 1915(b)(3) services. The principles are intended to highlight concepts and policy goals (i.e., **what** the policy guidance is intended to accomplish). The requirements are intended to outline operational details (i.e., **how** the policy goals will be pursued).

1) **Aggregate spending**
   - *General principle*—Under a 1915(b) waiver, combined spending on State Plan and 1915(b)(3) services cannot exceed what would have occurred without the waiver. In other words, States cannot spend more on 1915(b)(3) services than they save on State Plan services under the waiver.
   - ➢ *Requirement*—Combined spending on State Plan and 1915(b)(3) services cannot exceed projected spending during any given waiver period.

2) **Base-year spending (R2 for renewals) (for waiver projections)**
   - *General principle one*—Spending for 1915(b)(3) services should not exceed the cost of providing these services.
   - *General principle two*—Spending for 1915(b)(3) services should not exceed the "budget" for these services, as determined in a state's waiver application.
   - ➢ *Requirement (for initial waiver applications)*—The base year amount for 1915(b)(3) services under a new waiver application is limited to the lower of:
     a. Expected costs for the 1915(b)(3) services or
     b. Projected savings on State Plan services
   - ➢ *Requirement (for Renewals and Conversion Renewals)*—The base year (R2 for renewals) amount for projecting spending on 1915(b)(3) services under a waiver renewal is limited to the lower of:

a. Actual costs for 1915(b)(3) services under the current waiver or
b. Projected costs for 1915(b)(3) services under the current waiver (P2 in the previous submittal)

3) Growth in spending (price increases and use of services, but not changes in enrollment)

- *General principle one*—Growth in spending on 1915(b)(3) services cannot exceed growth in spending for State Plan services under the waiver. (This ensures that savings on State Plan services for both initial waiver and renewal periods finance spending for 1915(b)(3) services.)
- *General principle two*—Growth in spending on 1915(b)(3) services cannot exceed historical growth in spending for these services. (This ensures that growth in spending on waiver services is reasonable for the particular services.)
- ➢ *Requirement*—Growth in spending for 1915(b)(3) services is limited to the lower of:
  a. The overall rate of trend for State Plan services, or
  b. State historical trend for 1915(b)(3) services

4) Covered services

- *General principle*—If a state wants to expand 1915(b)(3) services, the State must realize additional savings on State Plan services to pay for the new services.
- ➢ *Requirement*—Before increasing its budget for 1915(b)(3) waiver services, a state must submit an application to CMS to modify its waiver (or document the modification in its renewal submittal). This application must show both:
  a. How additional savings on State Plan services will be realized, and
  b. That the savings will be sufficient to finance expanded services under the waiver
- *Special case*—A state also could be required to cut back (b)(3) services because of increased use of State Plan services.

5) Payments

- *Requirement*—As a condition of the waiver, capitated 1915(b)(3) payments must be calculated in an actuarially sound manner.

States must calculate a separate capitation payment for 1915(b)(3) services using actuarial principles and the same guiding principles as the regulation at 42 CFR 438.6(c) -with the exceptions that the 1915(b)(3) rates are based solely on 1915(b)(3) services approved by CMS in the waiver and the administration of those services. The actual payment of the 1915(b)(3) capitated payment can be simultaneous with the payment of the State Plan capitated payment and appear as a single capitation payment. However, the State must be able to track and account for 1915(b)(3) expenditures separately from State Plan services.

1915(b)(3) services versus 42 CFR 438.6(e) services. Under a 1915(b) waiver, 1915(b)(3) services are services mandated by the State and paid for out of State waiver savings. 42 CFR 438.6(e) services are services provided voluntarily by a capitated entity out of its capitated

savings. A State cannot mandate the provision of 42 CFR 438.6(e) services. In order to provide a service to its Medicaid beneficiaries, the State must have authority under its State Plan or through a waiver such as the 1915(b)(3) waiver. 1915(c) and 1115 Demonstration waivers also have authority for the provision of services outside of the Medicaid State Plan. CMS will match managed care expenditures for services under the State Plan or approved through an approved waiver. The State cannot mandate the provision of services outside of its State Plan or a waiver.

Initial waivers must estimate the amount of savings from fee-for-service that will be expended upon 1915(b)(3) services in the initial waiver. The State must document that the savings in state plan services, such as reductions of utilization in hospital and physician services, are enough to pay for the projected 1915(b)(3) services. If the State contends that there is additional state plan savings generated from the (b)(3) services those can only be documented after the State has documented that state plan-generated savings are enough to pay for the 1915(b)(3) Costs. Trend for 1915(b)(3) services in the initial waiver can be no greater than State Plan service trend (because there is no historic 1915(b)(3) service trend rate) as noted in the adjustments section.

The State must separately document Medical Assistance service expenditures and State administrative costs related to those services. Case management fees paid to providers in a PCCM program should be included as Medical Assistance service expenditures.

A State may make changes to their Medicaid and/or Medicaid waiver programs (e.g., changes to covered services or eligibility groups) during the period of time covered by an existing waiver. When the State makes these changes and there is a cost impact, CMS will require States to submit amendments which will modify P1 and P2 of the existing waiver calculations. By amending the existing P1 and P2 the State will ensure that when the State does its subsequent Renewal Waiver the R1 and R2 actual expenditures do not exceed the previous waiver's P1 and P2 expenditures solely as a result of the change to the Medicaid and/or Medicaid waiver program.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY eligible member months (R2 if a renewal). *See the example spreadsheets.*

Step 3. List the weighted average PMPM calculated in Appendix D3 for Initial, Conversion or Comprehensive Renewal waivers.

Expedited Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D. To calculate the PMPM by MEG, the State should divide the cost from Schedule D for R2 and by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts.

Step 4. In **Appendix D5**, list the program adjustments percentages and the monetary size of the adjustment by MEG as applicable for State Plan services. The State may then combine all

adjustment factors which affect a given MEG, and apply the adjustments accordingly. The derivation of a combined adjustment factor must be explained and documented.

Note adjustments in different formats as necessary. *See the Nebraska example spreadsheet as an example only. Some adjustments may be additive and others may be multiplicative. Please use the appropriate formula for the State's method.*

Step 5. Compute the PMPM projection by MEG by adding the service, incentive, administration, and 1915(b)(3) costs and the effect of all adjustments. These amounts need to be reflected in the State's next waiver renewal. These amounts represent the final PMPM amounts that will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes among MEGs when submitting their next waiver renewal cost-effectiveness calculations. In the subsequent renewal, the State should have PMPM Actual Waiver costs for each MEG for the 2-year period equal to or less than these Projected PMPM Waiver Costs for each MEG.

Appendix D6 – RO Targets

For the purpose of on-going quarterly monitoring in the future period, the State must document total cost and PMPM cost projections for RO use. The ROs will be using a two-fold test: one that monitors for overall growth in waiver costs on the CMS-64 forms and another that monitors for PMPM waiver cost-effectiveness. The State projections for RO use in both tests are in Appendix D6.

The first test projects quarterly aggregate expenditures by MEG for RO use in monitoring CMS 64.9 Waiver, CMS 64.21U Waiver, and CMS 64.10 Waiver expenditures during the upcoming waiver period. On a quarterly basis, CMS will compare aggregate expenditures reported by the State on CMS-64 Waiver forms to the State's projected expenditures (P1 and P2) included in the State's cost-effectiveness calculations as a part of the quarterly CMS-64 certification process. As part of the waiver submission, the State must calculate and document the projected quarterly aggregate Medical Assistance services and State administrative expenditures for the upcoming period. This projection is for the population covered under the waiver and will assist RO financial staff in monitoring the total waiver spending on an on-going basis.

The second test projects quarterly PMPM expenditures by MEG for RO use in monitoring waiver cost-effectiveness in the future waiver period. Because states are required to demonstrate cost-effectiveness in the historical two-year period of each Renewal Waiver, CMS intends to monitor State expenditures on an ongoing basis using the State's CMS-64 Waiver submissions. CMS will determine if the State's quarterly CMS-64 Waiver submissions support the State's ability to demonstrate cost-effectiveness when the State performs its Renewal Waiver calculations. For the second test, States are not held accountable for caseload increases. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG)

for each waiver year. The State must submit member month data corresponding to the quarterly submission of the CMS-64 on an on-going basis. The State should ensure that the member month data submitted on an on-going basis is comparable to the member month data used to prepare the P1 and P2 member month projections. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months**.

Step 2. List the P1 and P2 projected member months by quarter for the future period.

Step 3. List the P1 and P2 MEG PMPM cost projections from **Appendix D5**. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State will calculate the weighted average PMPM with Casemix for P1 and P2 (respectively).

Renewal P1	Renewal P2
P1 PMPM Costs x P1 MM P1 MM	P2 PMPM Costs x P2 MM P2 MM
Casemix for P1	Casemix for P2

The State is calculating the PMPM with Casemix for P1 and P2 so that the Region can compare the projected PMPMs to the actual PMPMs for administration (the State is calculating all of the PMPMs but only the administration PMPM will be used in Appendix D6). Administration is an area of risk for States in a 1915(b) waiver. If a State does not enroll enough persons into the program to offset high fixed administration costs, the State is at risk for not being cost-effective over the two year period. The Region will use this particular weighted PMPM to monitor State enrollment levels to ensure that high administrative costs are more than offset on an on-going basis.

Step 4. Multiply the quarterly member month projections by the P1 and P2 PMPM projections to obtain quarterly waiver aggregate targets for the waiver. *See the example spreadsheets.*

For the first aggregate spending test, the State will use the MEG PMPM from Appendix D5 multiplied by the projected member months to obtain the aggregate spending. The MEG PMPM from Appendix D5 is the number that States will be held accountable to in their waiver renewal. However, States will not be held accountable to the projected member months in their waiver renewal. For this reason, a second test modifying the demographics to reflect actual caseload is necessary.

CMS draft form

		Total PMPM	Q1 Quarterly Projected Costs		
Medicaid Eligibility Group (MEG)	**Total PMPM Administration Cost Projection**	**Projected Service Costs**	**Member Months Projections**	**64.9W /64.21U W Service Costs include incentives**	**64.10 Waiver Administration Costs**
MCHIP - MCO/PCCM/PIHP (3 co.)					
MCHIP - PIHP statewide					
Title XIX MCO/PCCM/PIHP (3 co)					
Title XIX – PIHP statewide					
Total					
Weighted Average PMPM Casemix for P1 (P1 MMs)					

Step 5. Create a separate page that documents by quarter Form 64.9 Waiver, Form 64.21U Waiver, and Form 64.10 Waiver costs separately for ease of RO CMS-64 monitoring. *See the example spreadsheets.*

Example:

Projected Year 1 - July 1, 2002 - June 30, 2003

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs Start 7/1/2002
64.21U Waiver Form	MCHIP - MCO/PCCM/PIHP (3 co)	$
64.21U Waiver Form	MCHIP - PIHP statewide	$
64.9 Waiver Form	Title XIX - MCO/PCCM/PIHP (3 co)	$
64.9 Waiver Form	Title XIX - PIHP statewide	$
64.10 Waiver Form	All MEGS	$

Step 6. Create a separate page that documents by quarter PMPM MEG costs separately for each of RO monitoring. Please include space for RO staff to list actual member months and aggregate totals by quarter. Please include formulas for RO staff to calculate actual PMPMs by quarter for comparison to projections. *See the example spreadsheets.*

For the second test, the State will carry forward the P1 (and P2 respectively) MEG PMPM

services costs and the weighted average PMPM administration costs Casemix for P1 (and P2 respectively).

Divide the actual aggregate costs by the actual aggregate member months (MM) to get PMPM actual costs**.** The State will divide the costs of the program by the caseload for the same quarter from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each quarter of the waiver. In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

On-going Actual P1 Q1	On-going Actual P2 Q5
P1 Q1 Actual Costs P1 Q1 Actual MM	P2 Q5 Actual Costs P2 Q5 Actual MM
Casemix for P1 Q1 actual	Casemix for P2 Q5 actual

On an on-going basis, the State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms. The RO analyst will enter the member month and CMS-64 form totals into the worksheet, which will calculate the actual MEG PMPM costs. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected PMPM expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions.

Example

Waiver Form	**Medicaid Eligibility Group (MEG)**	**State Completion Section - For Waiver Submission**	**RO Completion Section - For ongoing monitoring**		
			Q1 Quarterly Actual Costs		
		P1 Projected PMPM From Column I (services) From Column G (Administration)	**Member Months Actuals Start 7/1/2002**	**Actual Aggregate Waiver Form Costs**	**Actual PMPM Costs**
64.21U Waiver Form	MCHIP - MCO/PCCM/PIHP (3 co.)				#DIV/0!
64.21U Waiver Form	MCHIP - PIHP statewide				#DIV/0!

64.9 Waiver Form	Title XIX - MCO/PCCM/PIHP (3 co)				#DIV/0!
64.9 Waiver Form	Title XIX - PIHP statewide				#DIV/0!
64.10 Waiver Form	All MEGS				#DIV/0!

Appendix D7 - Summary
Document the State's overall cost-effectiveness analysis by waiver year.

In a renewal analysis, the State must clearly demonstrate that the PMPM actual waiver expenditures did not exceed the projected PMPM waiver expenditures for the population covered by the waiver. *For example, suppose a State's Initial Waiver (ST 01) considered years 2003 and 2004 to be P1 and P2 respectively. In the subsequent Renewal Waiver (ST 01.R01), the State's R1 and R2 will also be years 2003 and 2004, respectively. The State must demonstrate that in total the actual expenditures in the current Renewal Waiver's R1 and R2 (2003 and 2004) did not exceed the total projected expenditures in the Initial Waiver's P1 and P2 (2003 and 2004). Taking the example above, a State would use the actual expenditures from 2003 and 2004 as the basis for projecting expenditures for the renewal waiver period 2005-2006 (P1 and P2 respectively). In the second Renewal Waiver (ST 01.R02), the actual expenditures in the renewal period for 2005-2006 (R1 and R2) must be less than the expenditures for 2005-2006 (P1 and P2) projected in the previous renewal (ST 01.R01). For each subsequent renewal, the State will compare actual expenditures in R1 and R2 to the projected P1 and P2 values from the previously submitted Renewal Waiver.*

Cost-effectiveness will be determined based on the sum of Medical Assistance service expenditures and State administrative costs on a PMPM for the two-year period. In this instance, the weighted PMPM for both the projection and the actual cost is based on the Casemix for actual enrollment in R1 and R2. In this way, the State is not held accountable for any caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.

Step 1. List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

Step 2. List the BY (R1 and R2 if a renewal), P1 and P2 annual projected member months.

Step 3. List the BY (R1 and R2 if a renewal), P1 and P2 PMPM projections from **Appendix D5**.

List and calculate the weighted average PMPM at the Casemix for that year and at the Casemix

Year	Calculation	Where Already Calculated	Formula
BY	BY Overall PMPM for BY (BY MMs)	Appendix D3	BY Aggregate Costs BY MM
P1	P1 Weighted Average PMPM Casemix for BY (BY MMs) P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	 Appendix D6	P1 PMPM x BY MM BY MM P1 PMPM x P1 MM P1 MM
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs) P2 Weighted Average PMPM Casemix for BY (BY MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	 Appendix D6 Appendix D6	P2 PMPM x P1 MM P1 MM P2 PMPM x P2 MM P2 MM P2 PMPM x BY MM BY MM P2 PMPM x P2 MM P2 MM

for the previous year. In other words, calculate the PMPM for that year's demographics and for the previous year's demographics so that CMS can compare the PMPM for the enrolled caseload to the PMPM holding the caseload's demographics constant. In short, the new PMPM times the old MM (new dollars times old weights = Casemix effect for old MM) is the Casemix for the old MM.

Initial or Conversion Waiver

Renewal Waiver

Year	Calculation	Where Already Calculated	Formula
R1	R1 Overall PMPM for R1 (R1 MMs)	Appendix D3	R1 Aggregate Costs R1 MM
R2	R2 Weighted Average PMPM Casemix for R1 (R1 MMs) R2 Overall PMPM for R2 (R2 MMs)	 Appendix D3	R2 PMPM x R1 MM R1 MM R2 Aggregate Costs R2 MM
P1	P1 Weighted Average PMPM Casemix for R2 (R2 MMs) P1 Weighted Average PMPM Casemix for P1 (P1 MMs)	 Appendix D6	P1 PMPM x R2 MM R2 MM P1 PMPM x P1 MM P1 MM
P2	P2 Weighted Average PMPM Casemix for P1 (P1 MMs) P2 Weighted Average PMPM Casemix for P2 (P2 MMs) P2 Weighted Average PMPM Casemix for R1 (R1 MMs)	 Appendix D6	P2 PMPM x P1 MM P1 MM P2 PMPM x P2 MM P2 MM P2 PMPM x R1 MM R1 MM

	P2 Weighted Average PMPM Casemix for P2 (P2 MMs)	Appendix D6	P2 PMPM x P2 MM / P2 MM

Step 4. Calculate a total cost per waiver year. Multiply BY MM by BY PMPM. (Renewal Waiver, multiply R1 MM by R1 PMPM and multiply R2 MM by R2 PMPM) Multiply P1 MM by P1 PMPM. Multiply P2 MM by P2 PMPM. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

Step 5. Renewal Waiver only - Calculate the Total Previous Waiver Period Expenditures (Casemix for R1 and R2). *Note: the Total Cost per Waiver for R1 should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

Step 6. Calculate the Total Projected Waiver Expenditures for P1 and P2.

Step 7. Calculate the annual percentage change. For Initial and Conversion waivers, calculate the percentage change from BY to P1, P1 to P2 and BY to P2 for each MEG. For renewals, calculate the percentage change from R1 to R2, R2 to P1, P1 to P2, and R1 to P2 for each MEG. Calculate the annual percentage change for the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the annual percentage change in the PMPM compared to the previous year for that year's demographics and for the previous year's demographics. This allows CMS to compare the percentage of the PMPM that changed due to the caseload's demographics changes. The sample spreadsheets have appropriate formulas for State use. Explain these percentage changes in the State Completion section.

Step 8. Renewal Waiver only - list the PMPM cost projections (P1 and P2) by MEG from the previous waiver submittal.

Step 9. Renewal Waiver only - Calculate the Actual Previous Waiver Period Expenditures, Total Projection of Previous Waiver Period Expenditures, and Total Difference between Projections and Actual Waiver Cost for the Previous Waiver using actual R1 and R2 member months. Using actual R1 and R2 member months will hold the State harmless for caseload changes. Multiply the PMPM projections by the actual R1 and R2 member months to obtain the overall expenditures for the past Waiver Period. Subtract waiver actual waiver costs for R1 and R2 from the projected PMPM program costs previously submitted (P1 and P2 in the previous waiver submission) to obtain the difference between the Projections and Actual Waiver Cost for the retrospective period. If **Actual Waiver Service Cost plus the Actual Waiver Administration Cost is less than or equal to Projected Waiver Cost,** then the State has met the Cost-effectiveness test and the waiver may be renewed.

IV. State Completion Section

A. Assurances

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

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

b. Name of Medicaid Financial Officer making these assurances: Wendi Gunther

c. Telephone Number: (360) 902-0825

B. For Renewal Waivers only - Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.__**X**_ The State provides additional services under 1915(b)(3) authority.

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

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

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

box and process the waiver using the Comprehensive Test.

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

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

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

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

The response to this question should be the same as in **A.III.a**.

a.___ Risk-comprehensive (fully-capitated--MCOs, HIOs)
b._x__ Partial risk/ PIHP
c.___ Partial risk/ PAHP
d.___ Other (please explain):

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

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe). Responses must match those provided in **Section A.IV.C.4 (PCCM-only preprint – n/a in capitated-only preprint)**:

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

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.IV.I**.d.2, 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. Response can be included in

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

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

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:____

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

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

For Conversion or Renewal Waivers:

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

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State estimated up to six (6) months of enrollment data for R2 of the previous waiver period. Note the length of time estimated: ______

c.__x_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: 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. State-Funded Medical Care Services. 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.

Some of the factors considered in developing the caseload forecast include actual enrollment, changes, eligibility verification, and impact of medical premiums. Each of these factors may end up creating a higher or lower forecast. This forecasting process is done officially twice a year, once in November and once in February. The percentage increase as reflected in D1 is 2.5% in year one and 3.5% in year two.

d. _x__[Required] Explain any other variance in eligible member months from BY/R1 to P2: No other source of variance.

e.__x__[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: The base year is SFY 2004.

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

For Initial Waivers:

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

For Conversion or Renewal Waivers:

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

b._x__ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: Only state psychiatric services (which includes state hospitals and state only funded programs) are not included, per CMS direction. In Appendix D2.S, those services with boxes checked in Column H are included in the Waiver, are included in the capitation payment, and are included in Appendix D3 in Column D. Those services with boxes checked in Column I are fee-for-service items not in the Mental Health Waiver that are included in Appendix D3 in Column E.

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. The allocation method is explained below:

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

b.__x_The State allocates administrative costs based upon the program cost as a

percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

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

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

Respite, Clubhouse, and Supported Employment Services	*$1,211,667*	*2.6% per annum*	*P1: $1,142,710* *P2: $1,214,819*

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

Basis and Method:

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

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

3. _X_ In addition to the taxing authority of the counties, the state requires that each RSN hold risk 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.

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.IV.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.IV.I.e and D.IV.J.f)**

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.

I. Appendix D4 – Adjustments in the Projection

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

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

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

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: __________. Please document how that trend was calculated:

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

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

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

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

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

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

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

approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.

Others:

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

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

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

v.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State

Plan Amendment (SPA). PMPM size of adjustment _______
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _______
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _______
D.____Other (please describe):

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

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

cost increase calculation includes more factors than a price increase.

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

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

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

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

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

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

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.IV.G.d.2**, 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.IV.I.a**._______

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

3. Explain any differences:

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

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

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

3.___ Other (please describe):

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

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

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any payments or recoupments made should be accounted for in **Appendix D5.**
1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
Basis and Method:
1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.
1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the

beginning of P1. Please account for this adjustment in Appendix D5.

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

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

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

*For Combination Capitated and PCCM Waivers: If the MCO/PIHP/PAHP will collect and keep TPL recoveries, then the PCCM Actual Waiver Cost must be calculated less the TPL recovery amount expected in the PCCM program. For additional information, please see Special Note at end of this section.

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

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

2._X_The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs

that are paid for by the State in FFS.

3.___ Other (please describe):which includes accounting for Part D dual eligibles.

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

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

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

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

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

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

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

2.___ This adjustment was made:

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

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

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

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

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

3.___ Other (please describe):

4.___NA__ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment. The State has not made this adjustment. FQHC's may be subcontractor' of the mental health PIHP however, they are paid by mental health in the same manner as any other subcontractor.

Special Note section:

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

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

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

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an	The PCCM Actual Waiver Cost must include an exact offsetting

Adjustment	Capitated Program	PCCM Program
	administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).
Third-Party Liability Adjustment	The MCO will collect and keep TPL recoveries. The Capitated Waiver Cost Projection is created less the Third-Party Liability amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment.	The PCCM Actual Waiver Costs must be calculated less the TPL recovery amount expected in the PCCM program.
Pharmacy Rebate Adjustment	The Capitated Waiver Cost Projection is created less the pharmacy rebate amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment.	The PCCM Actual Waiver Costs must be calculated less the pharmacy rebate amount expected in the PCCM program.

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

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

for the purposes of this analysis.

1.___ No adjustment was made.

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

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

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

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

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

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1]

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

i. __x__ State historical cost increases. Please indicate the years on which the rates are based. base years: *State Fiscal year 2004.* In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). *The method used is a simple algebraic projection.* Finally, please note and

explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. *N/A*

ii. _ __ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs:

All trend rates below are annual rates:

- Capitated State Plan Services — 2.8% (this represents a blend of 2.6% for outpatient services and 3.9% for inpatient services). Documentation of trend rates for capitated rates are more fully explained in the Actuarial Study by Milliman, Inc., dated June 2, 2005.
- Capitated b(3) services — 2.6%, same as outpatient capitated services.
- Pharmacy (prescription drugs) — 14.1% for Disabled and 17.1% for Non-Disabled. These rates are based on historical WA State claims data from FY 2003 – 2005.
- Non-capitated (FFS) physician servces — 2.6%, consistent with outpatient capitated services.
- Children's Long Term Inpatient services — 3.2%, based on WA State budget projection.
- Behavioral Rehabilitation Services — (1.1%), based on WA State budget projection.
- Division of Alcohol and Substance Abuse — 19.8%, based on WA State budget projection.
- Involuntary Treatment Act Ancillary — 2.6%, based on WA State budget projection.
- Actual State Administration costs trended forward at the State Plan Service Trend rate of 7.7%.

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

All trends reflect cost and utilization.

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

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

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

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

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (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.__X__ An adjustment was necessary and is listed and described below:

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

For each change, please report the following:

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

B.____X The size of the adjustment was based on the reduction of $3.34

in the high end actuarial range of the capitated State Plan program, as documented in the Actuarial Study (June 2, 2005).

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

D.____Other (please describe):

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

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

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

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

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

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

D.____Other (please describe):

v.__ **X** Changes in legislation (please describe):
For each change, please report the following:

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

B.____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.____**X** Other (please describe): Spending on prescription drugs is projected to decrease for the dual eligible population starting in Calendar Year 2006, due to coverage of drugs by Medicare Part D. This is a reduction of $6.93 pmpm.

vi.__ Other (please describe):

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

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

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

D.____Other (please describe):

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization

Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

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

2._**X**_ An administrative adjustment was made.

i.___ 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.____Other (please describe):

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

Administrative costs include a percentage allocation of the Mental Health Division's administrative costs based on the monthly percentage of Medicaid expenditures as compared to all community expenditures. It also includes transportation, prevalence study, longitudinal study, Medicaid Management Information Services, Children's Long Term Inpatient Administration, performance outcome study, CMS surveys, Dangerous Mentally Ill Offender and Mentally Ill Offender studies, HIPAA, Actuary, Benefits Notice, and External Quality Review Organization costs.

Aggregate historical administrative cost increases for ongoing

services (excluding new requirements such as EQRO, HIPAA compliance, etc.) was calculated to be 3.0%. This rate is less than the historical trend rate for state plan services, as noted below. As per CMS instructions, costs for new administrative requirements in the projection years were used to proxy similar costs in the base year by backing out the trend assumption. Ongoing services were based on the 3.0% trend rate.

Please note that this trend rate was computed based on aggregate MHD administrative expenditures, not PMPM administrative expenditures. Column Y expresses the administration cost trends on a PMPM basis, which is why it differs from the 3.0%.

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

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1.

2.__X_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

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

1. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.IV.J.a**. above: 2.6%* for disabled and non-disabled. These trend rates are consistent with the trend rates for state plan outpatient services included in the waiver.

**In Appendix D.5 the percentage calculates differenly due to a combination of program and trend adjustments.*

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

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

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

3. Explain any differences:

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ XX No adjustment was made.

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

For the conversion waiver, pharmacy rebate factor adjustment is not reflected in either the base year or the projected year. The rebate is reflected in the CMS 64 but not in our calculation as they are reflected in the MAA fee-for-service system. The drug rebates do not flow through the MMIS system. If CMS requires an allocation of the drug rebate both the 64 and this projection will need to be revised.

K. Appendix D5 – Waiver Cost Projection

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

L. Appendix D6 – RO Targets

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

M. Appendix D7 - Summary

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

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.IV.E. c & d**: Disabled 0.4%, Non-Disabled 0.1%

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.IV.I and D.IV.J**: Disabled 4.7%, Non-Disabled 4.2%

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.IV.I and D.IV.J**: Disabled -8.6%, Non-Disabled -3.0%

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

The following questions were asked of the MHD in the request for the waiver modification submitted in August 2003. For consistency the MHD is providing the response in this waiver renewal request.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking Washington to confirm to CMS that the WA Integrated Community Mental Health Services program retains 100 percent of the payments. Does the WA Integrated Community Mental Health Services program retain all of the Medicaid capitation payment and not participate in such activities as intergovernmental transfers or certified public expenditure payments, including the Federal and State share; or, is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the WA Integrated Community Mental Health Services program is required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (ie, general fund, medical services account, etc.)

The RSN keeps 100 percent of the capitation payment.

2) Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state's share of the Medicaid capitation payment for the WA Integrated Community Mental Health Services program is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for the Medicaid capitation payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

The system operated under a 1915 (b) waiver is currently allocated for state matching funds for the 05 07 biennium by the legislature for the amount of $$164, 545,000 for FY 04 and $166, 044,000 for FY 05. In our current system operated by the Regional Support Networks there is legislative authority for the use of local funds up to $11,995,000 for FY 04 and $11,854,000 for FY 05. These funds may be county millage through taxing authority of the Regional Support Networks or other state funds available to the Regional Support Networks at the local level that has not been matched by any other federal fund. The Regional Support Network must inform the MHD at the start of the biennium the amount of local funds they will be using annually. The RSNs must certify yearly their actual use of local funds. When the RSNs certify clean state funds, MHD fiscal staff verifies with the state agency providing these funds that it had no way been used as matching funds for any program.

3) Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to WA Integrated Community Mental Health Services program.

No supplemental or enhanced payments are made.

4) Do any of the capitation payments to the WA Integrated Community Mental Health Service program exceed the amount certified as actuarially sound as required under MMC regulations at 42 CFR 438.6 (c)? If so, does the state recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

No capitation payment exceed the actuarially sound rate.

Appendices D1-D7 **Cost effectiveness in this conversion renewal waiver is built on rates pending approval from CMS submitted with the waiver modification August 1, 2003.**

All appendix D Spreadsheets are submitted electronically and are attached at the end of this document.

Section E. FRAUD AND ABUSE
States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. [Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)]

The State Auditor monitors and reported no findings of Fraud and Abuse. Staff from MHD and the RSNs attended training provided by CMS. The EQRO found no evidence of fraud and abuse in their review.

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes.

I. State Mechanisms

a._X_ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

b.___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c._X_ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

The State auditor monitors for fraud and abuse. These reports have been submitted to CMS over the course of the waiver. There have been no findings.

d._X_ The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe.
The contract with the PIHP includes the marked terms from II. b. below.

e.___ Other (please describe):

II. MCO/PIHP/PAHP Fraud Provisions

a._X__[Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:
(i) data is accurate, complete, and truthful based on best knowledge, information, and belief
(ii) certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO
(iii) certification is submitted concurrently with data

PIHPs are paid on a per member per month basis for all Medicaid enrollee. The RSN Administrator is required to provide daily written certification which attests, based on their best knowledge, information, and belief, the accuracy, completeness, and truthfulness of data submitted to the MHD.

b._X___[Required for MCO/PIHPs]The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:
(i)_X_Written polices that articulate commitment to comply with all applicable Federal and State laws
(ii)_X_Designation of compliance officer and committee
(iii)_X__Effective training and education for compliance officer and plan employees
(iv)_X_ Enforcement of standards through well-publicized disciplinary guidelines
(v)_X_ Provision for internal monitoring and auditing
(vi)_X_ Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract

c. _X_ [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who is, or who is affiliated with, an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. _X_ The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. SPECIAL POPULATIONS

States may wish to refer to the October 1998 CMS document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint, item F.I. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

b. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- Please check all items that apply to the State.

a._X_ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals (with medicaid), Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

This is a carved-out mental health program. The program is responsible for persons (with the exceptions of the excluded populations) of all ages who qualify for authorization to services through the access to care standards and meet the definition of medically necessary. The program does not discriminate based on physical disability nor does the program meet the criteria for primary care provider. Mental health services are specialty services.

b._X_ There are special populations included in this waiver program.

Please list the populations.

Per CMS definition, Children, adults and older adults with mental illness or serious emotional disturbance.

c._X_ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies that serve special needs consumers, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

The PIHPs have over the course of the current waiver period developed cross-system service protocols for children and older adults. These protocols are scheduled to be updated. The RFQ is asking many questiond regarding cross-system collaboration.

d.___ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2.___ State/local funding sources
3.___ Other (please describe):

e.___ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.___ Access to services (please describe):
2.___ Quality of Care (please describe):
3.___ Coordination of care (please describe):
4.___ Enrollee satisfaction (please describe):
5.___ Other (please describe):

f._X__ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

MHD's QA & I team reviews new (provisional license) agencies for ADA compliance. They request the latest self-assessment for ADA compliance and look for any corrective actions. If they are county or RSN contractors QA &I ask to see their latest review activities on this issue. If the agency can't provide documentation of ADA evaluation then look about to see if there are any major access barriers (disabled parking, rails in bathrooms, wheel chair accessible, etc.). Often times, QA & I will request the completion the ADA form with a copy provided to MHD.

g.___ The State has specific performance *indicators* ~~measures~~ and performance improvement projects for the populations ~~with special health care needs~~. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

Please see the Mental Health Division website at http://www1.dshs.wa.gov/mentalhealth and the WIMIRT website http://depts.washington.edu/washinst.

II. State Requirements for MCOs/PIHPs/PAHPs

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint, item F.II. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

Upcoming Waiver Period Please check all the items that apply to the State or MCO/PIHP/PAHP.

a.___ The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.

b.___ As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO/PIHP/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.

c.___ The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d.___ The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If not checked, please explain by population.

e.___ The State collects or requires MCOs/PIHPs/PAHPs to collect population-

specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in Appendix D.2.S that are for special needs populations only by population.

2. Please note any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance?

g.___ The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the conditions.
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the MCO/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure 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 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

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

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

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

I. Definitions (MCO/PIHP):

Upcoming Waiver Period --

a. **_X_** [Required]The definition of action in the case of an MCO/PIHP means:

- ✓ Denial or limited authorization of a requested service, including the type or level of service;
- ✓ The reduction, suspension, or termination of a previously authorized service;
- ✓ The denial, in whole or in part, of a payment for a service;
- ✓ The failure to provide services in a timely manner
- ✓ The failure to act within timeframes required by 42 CFR 438.408(b); or

For a resident of a rural area with only on MCO, the denial of the enrollee's request to exercise his or her right to obtain services outside the network.

b. **_X_** Appeal means a request for a review of an action.

c. **_X_** Grievance means an expression of dissatisfaction about any matter other than an action.

d. Please describe any special processes that the State has for persons with special needs.

II. Grievance Systems Requirements (MCO/PIHP):

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please

provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

The MHD has monitored grievance and fair hearing for the last several years. The current template and instructions for use in reporting complaints, grievances and fair hearings was put in use October, 2001. Data for adults and for children were combined on a one page summary report, to be submitted to MHD. In addition to reports of cases and occurrences of various types (e.g. dignity and respect), RSNs are expected to report the corresponding resolutions to the occurrences of types of complaints.

Regional Support Networks are now considered to be proficient in its use. Reports are due November 15 and May 15 each year. They are received on a timely basis.

RSNs vary in their ability to conduct analyses of raw data. Some of them have incorporated use of complaint data into their ongoing quality monitoring and management processes.

The PIHPs have gained a better understanding of their responsibility when a denial of service is initiated due to an enrolled consumer not meeting the definition of medical necessity for service.

b. Please mark any of the following that apply:

1.___ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2._X_ Following this section is a list or chart of the number and types of ~~complaints~~ ~~and/or~~(not required per BBA and CMS) grievances handled during the waiver period.

October 2004 through March 2005

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Access	1	1	2	
Dignity and Respect			2	
Quality/ Appropriateness	2	1	1	
Phone calls not returned	2			
Service -- Intensity, Not Available, Coordination	1		1	
Consumer Rights		1		

CMS draft form

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Physicians & Medications	3		1	
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services		1	1	
Other		1		

April 2004 through September 2004

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Access	1	1		1
Dignity and Respect			1	
Quality/ Appropriateness			3	
Phone calls not returned				
Service -- Intensity, Not Available, Coordination			6	
Consumer Rights				
Physicians & Medications				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services			1	1
Other			2	2

3. **_X_** There is consumer involvement in the grievance process. Please describe. Consumers have the right to seek the services of Ombuds. Ombuds are required to be consumers or past consumers of mental health or family members of consumers of mental health. Consumers may also use other representation if they choose.

Upcoming Waiver Period -- Please check requirements in effect for MCO/PIHP grievance processes.

a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:

1. _X_ MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

2. _X_ An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits
   (A)__ direct access without first exhausting the MCO/PIHP grievance process

(B) X exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed with regards to specific mental health grievance the state requires the consumer to exhaust grievances at the lowest level possible; first at the community mental health agency, then the PIHP, and then the Mental Health Division. All must occur within 90 days.

Per DSHS rules a consumer may access fair hearing at any time for issues with regards to DSHS rules.

3. _X_ Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

4. _X__The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame _20 days _

5. _X_ [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State __90days___

The regional support network must have in place a system for reviewing and resolving consumer grievances. The process must comply with WAC 388-865-0255 or its successor.

6. _X_ The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7. _X_ The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to

be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:

8. **X** The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

9. **X** The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.

10. **X** The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

11. _X_ The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12. **X** Timeframes for resolution:

    (a) **X** Grievances are resolved within _90__ days (may not exceed 90 days from date of receipt by MCO/PIHP)

    (b) **X** Standard appeals are resolved in 45_ days (may not exceed 45 days from date of receipt by MCO/PIHP).

    (c) **X** Expedited appeals are resolved in _3 days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

13. **X** Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).

14. **X** The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).

15. **X** The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).

16. **X** The MCO/PIHP maintains an expedited review process for

appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.

17._**X**_The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).

18._**X**_ MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

19._**X**__The State reviews information on each MCO/PIHP's appeals as art of the State quality strategy.

20._**X**_The State and/or MCO/PIHP have ombuds programs to assist enrollees in the appeals, grievance, and fair hearing process.

21.___Other (please specify):

III. PAHP Requirements

1.__ [Optional] PAHPs have an internal grievance system. Please describe.

2.__ [Required] PAHP enrollees have access to the State fair hearing process.

Section H. ENROLLEE INFORMATION AND RIGHTS

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. Marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A

(see A.IV.a).

I. Information – Understandable; Language; Format

Previous Waiver Period

a. [Required] Please provide copies of the brochure and informational materials for potential enrollees explaining the program and ~~how to enroll~~ *mandatory enrollment*.

Attachment H. I. a.

CMS draft form

DSHS/Mental Health Division
PO Box 45320
Olympia WA 98504-5320
Phone: (360) 902-8070
Toll-free: 1-888-713-6010
Office of Consumer Affairs: 1-800-446-0259

Public Mental Health System
Benefits Booklet for People Enrolled in Medicaid

July 1, 2003

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Introduction and Overview

This is a booklet about mental health services available to people who receive Medicaid. In this booklet you will find:

- an explanation of what public mental health services are available;
- how those services are provided;
- where to get services;
- your rights as a person who receives those services
- how to protect your rights.

You will also find information about mental health services available in your service area. Service areas where mental health services are coordinated are known as Regional Support Networks (RSNs). You will learn about:

- areas served by each RSN;
- how to contact the RSNs or their authorized providers;
- how to access crisis services; and
- the languages in which services are available.

a. Definitions:

Community Mental Health Agency (CMHA) - A licensed facility providing mental health services. In this booklet, community mental health agencies will be called agencies.

Emergent Care - Service provided for a person that, if not provided, would likely result in the need for crisis intervention or for hospital evaluation due to concerns of potential danger to self, others, or grave disability.

Enrollee - An individual who is a Medicaid recipient and who has been enrolled in a mental health prepaid inpatient health plan.

Medical Necessity or Medically Necessary - A requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. Course of treatment may include mere observation or, where appropriate, no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit

from the intervention. Any other formal or informal system or support can not address the individual's unmet need.

Mental Health Care Provider (MHCP) - The individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services.

Mental Health Division (MHD) - The Division within the state Department of Social and Health Services (DSHS) with responsibility for public mental health services.

Mental Health Professional - An individual who meets the standards defined in Washington State law. The standards are based on how much education the person has and how much experience the person has in mental health. Most mental health professionals have a Master's Degree and at least two years experience in mental health. There are some exceptions which are defined in the law. Psychiatrists, psychologists, psychiatric nurses and social workers are all mental health professionals.

Ombuds Service - A person who can help you when you need to file a grievance or fair hearing.

Outpatient Service - Mental health services provided in the community.

Regional Support Network (RSN) - County or group of counties responsible for local public mental health services.

Urgent Care - To be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

b. Who is eligible for public mental health services?

Medicaid recipients are automatically enrolled in a local mental health managed care plan which is called the Regional Support Network (RSN). RSNs coordinate mental health services offered within their service area through contracts with community mental health agencies.

People who receive Medicaid coupons are eligible for medically necessary mental health services at no cost. Any person needing mental health crisis services is eligible to receive them. If you think that you may need mental health services, you can call or drop by one of the authorized agencies located in the RSN where you live to schedule an appointment to learn what you may need. A list of agencies begins on page 9. All services must be authorized by the RSN in your area. This process will happen between your agency and RSN.

c. What services are available?

Hospital and outpatient mental health services are available to you and your family if they are needed. Some of services include:

- Crisis services;

- Individual therapy;
- Group therapy; and
- Medication evaluation, prescription and management.

You may also receive employment support services, case management and other services through your RSN.

For more detailed information, please call the RSN for your community listed on the following pages or call the Mental Health Division (MHD) at 1-888-713-6010.

Interpreter services are available upon request. Most written materials are translated into languages other than English based upon the service area population.

Some community mental health agencies have staff who speak other languages besides English. There is more information on the page for your RSN. If you or someone you know wants services in another language, your RSN must provide language assistance at no cost to you. Assistance can be provided both orally and in writing.

If you need mental health services, an individual service plan will be developed with you. Your plan will consider your age and your culture. You may receive one or more of the services listed above. The plan will be fit to you, according to your strengths and needs. Your mental health care provider will decide with you which services you will be provided and for how long.

Your mental health care provider may also ask permission to work with people who provide you other services such as housing, healthcare, and employment.

Other Medicaid benefits may be available to you. Here are some reference numbers:

Physical health: **Contact information on back of your card**

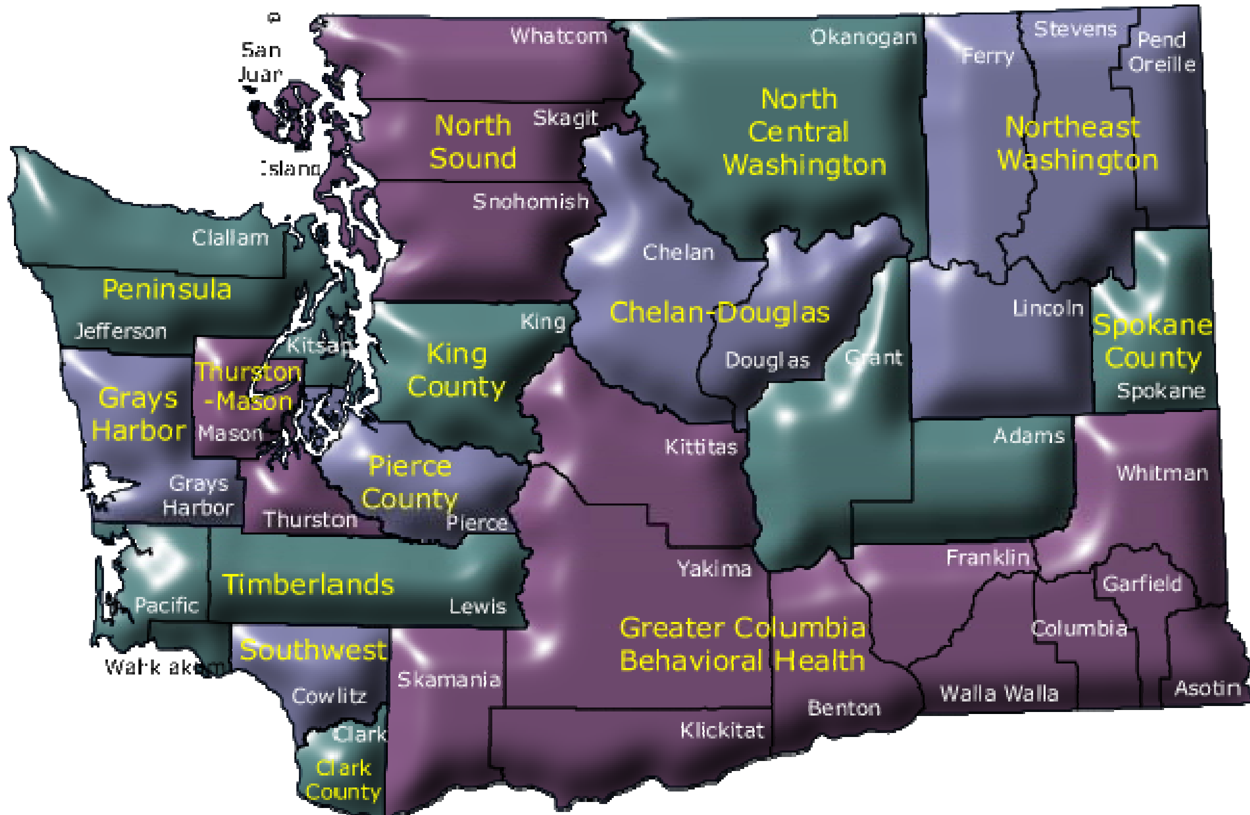
Substance Abuse: **1-877-301-4557**

Aging and Disabilities Services: **1-800-422-3263**
www.aasa.dshs.wa.gov

Transportation Broker: **1-800-562-3022/911 for crisis**

d. *Who provides services?*

The Washington State public mental health system has fourteen (14) Regional Support Networks (RSNs). They are made up of one or more counties that serve your county and community. Locate your RSN in the map or by your county listed below.



County	-	Regional Support Network
Adams	-	North Central WA RSN
Asotin	-	Greater Columbia Behavioral Health
Benton	-	Greater Columbia Behavioral Health
Chelan	-	Chelan-Douglas
Clallam	-	Peninsula
Clark	-	Clark County
Columbia	-	Greater Columbia Behavioral Health
Cowlitz	-	Southwest
Douglas	-	Chelan-Douglas
Ferry	-	Northeastern WA
Franklin	-	Greater Columbia Behavioral Health
Garfield	-	Greater Columbia Behavioral Health
Grant	-	North Central WA
Grays Harbor	-	Grays Harbor
Island	-	North Sound
Jefferson	-	Peninsula
King	-	King County
Kitsap	-	Peninsula
Kittitas	-	Greater Columbia Behavioral Health
Klickitat	-	Greater Columbia Behavioral Health

County	-	Regional Support Network
Lewis	-	Timberlands
Lincoln	-	Northeastern WA
Mason	-	Thurston-Mason
Okanogan	-	North Central WA
Pacific	-	Timberlands
Pend Oreille	-	Northeastern WA
Pierce	-	Pierce County
San Juan	-	North Sound
Skagit	-	North Sound
Skamania	-	Greater Columbia Behavioral Health
Snohomish	-	North Sound
Spokane	-	Spokane County
Stevens	-	Northeastern WA
Thurston	-	Thurston-Mason
Wahkiakum	-	Timberlands
Walla Walla	-	Greater Columbia Behavioral Health
Whatcom	-	North Sound
Whitman	-	Greater Columbia Behavioral Health
Yakima	-	Greater Columbia Behavioral Health

Accessing Public Mental Health Services

Each RSN contracts with licensed agencies to provide mental health services. A list of RSNs begins on page 9. The list shows the counties served by each RSN. It also shows the agencies that contract with the RSN to provide services. This booklet tells you how to contact those agencies if you need services.

You may only go to these authorized agencies for covered services. You may be responsible for costs if you receive mental health services through other providers.

e. What choices do I have?

You may choose a mental health care provider at the agency from which you receive services. If you don't choose a mental health care provider, one will be assigned. You have the right to change mental health care providers during the first 30 days. You can also ask for a change once a year for any reason. If you think you have a good reason, you can ask for more changes. The change may or may not be granted.

f. What if I need crisis services?

g. *If there is a life-threatening emergency, please dial **911**. If you have a mental health crisis you can call your RSN's crisis line. All RSNs respond to crises 24 hours every day. You can find your RSN's crisis line on the RSN list in this booklet starting on page 9.*

h. How can I get outpatient services?

If you think you need services, call the toll-free or local telephone numbers. Those are listed with other RSN information, starting on page 9.

Public mental health services are designed to keep you well in your own community. All efforts will be made to keep you from needing hospital care.

i. What if I needed to be in the hospital for my mental illness?

Psychiatric hospital services are available to Medicaid enrollees. These services are at no cost, but must be approved in advance. If you think you need to be hospitalized, contact your mental health care provider. Your provider will help you with hospital services if they are necessary.

j. What if I get a bill?

k. *If you received services from an agency that is not listed in this booklet, you may be responsible for costs. If your coupon was not active, you may have to pay. If you had a coupon and receive a bill for an agencies services in error, contact the agency billing office. If you need further help, contact your RSN.*

Your Rights

I. As a person receiving public mental health services, what are my rights?

YOU CAN EXERCISE THE FOLLOWING RIGHTS:

- *To be treated with respect and dignity*
- *To have your privacy protected*
- *To help develop a plan of care and services that meet your needs*
- *To participate in decisions regarding your mental health care*
- *To receive services in a barrier-free location (accessible)*
- *To request information about names, location, phones, and languages for local agencies*
- *The right to receive the amount and duration of services you need*
- *To request information about the structure and operation of the RSN*
- *The right to services within 2 hours for emergent care and 24 hours for urgent care*
- *To be free from use of seclusion or restraints*
- *To receive age and culturally appropriate services*
- *To be provided a certified interpreter and translated material at no cost to you*
- *To understand available treatment options and alternatives*
- *To refuse any proposed treatment*
- *To receive care that does not discriminate against you (e.g. age, race, type of illness)*
- *To be free of any sexual exploitation or harassment*
- *To receive an explanation of all medications prescribed and possible side effects*
- *To make an advance directive, which states your choices and preferences for mental health care*
- *To receive quality services that are medically necessary*
- *To have a second opinion from a mental health professional*
- *To file a grievance with your agency or RSN*
- *To choose a mental health care provider or choose one for your child who is under thirteen years of age*
- *To change mental health care providers during the first 30 days, and sometimes more often*
- *To file a request for an administrative (fair) hearing,*
- *To request and receive copy of your medical records and ask for changes*
- *Be free from retaliation*

You may want to ask your mental health care provider for more information about your rights. Your rights will be provided to you in writing when you request services. An independent Ombuds may be available in your RSN to help you if you have complaints. When you receive mental health care in a hospital, you have additional rights.

m. What is an advance directive for psychiatric care?

An advance directive is a document expressing an individual's treatment preferences in the event they experience symptoms of mental illness that would otherwise prevent them from making such decisions.

n. How do I complete one?

This is a new law and is effective on July 27, 2003. DSHS is developing training for agencies and service providers regarding advance directives. Your RSN can provide additional information regarding obtaining and completing an advance directive form.

o. Member Satisfaction

Once a year, the Mental Health Division does a survey to see what you or your child feel about the services you received. Questions are about access, quality and appropriateness. Your participation is voluntary, however, we strongly believe that your voice is the best way to improve the system. Therefore, we hope that if you are contacted, you will take the time to respond.

p. What is a complaint?

A complaint is an informal way to express your dissatisfaction. It's a good idea to try to resolve your complaint with the person directly involved or ask the Ombuds to assist you, before you try other things. Explain your concern. Let the person know what would work better for you. Be clear about what your complaint is. Also, be clear about what an acceptable solution will be. Try to find some ways to reach agreement that will satisfy both you and the other person.

q. What does an Ombuds do?

Ombuds receive complaints and help enrollees resolve them. Each RSN has an Ombuds Service that can assist you with the grievance process. See listing of Ombuds Service phone numbers listed for each RSN in this booklet beginning on page 9.

r. What is a grievance?

A grievance is a formal complaint. Examples include concerns about timely delivery of services, quality of services or feeling your rights have not been respected. All agencies have a grievance process. You can file a grievance at anytime. You may have someone represent you during the process. Ask your agency for a copy of their grievance procedure.

If you aren’t satisfied with a response to a grievance from your agency, your RSN also has a grievance process. Contact your RSN for information regarding their grievance process.

The next level in the grievance system is at the Mental Health Division. The process from the agency through the Mental Health Division must take no more than 45 days. During this time, your services and rights can not be changed or altered.

If your concern is about the following actions:

- Timely access (starting), stopping, or reduction of authorized services; or
- You received a bill for authorized services.

You may file an appeal with the RSN. You may first ask your RSN for a less formal review of an action however; this can take no more than 72 hours. You may make the request for appeal orally however, it must be followed-up in writing. The formal appeal process for reconsideration of an action is published by your RSN and is available to you within 15 days of your enrollment in the RSN.

You may request a hearing through the Office of Administrative Hearings (OAH). OAH is an independent part of state government that is responsible to decide whether a state regulation has been broken. This office can review actions about the agency that provides your services, about the RSN or both. If state rules haven't been followed correctly, the Administrative Law Judge (ALJ) can order state agencies and their contractors (including RSNs and mental health agencies) to "make it right". You will have the ability to present evidence, in person or in writing, the right to bring representation, and the right to see your file.

If you choose, you can also ask for the Office of Administrative Hearings to hear your concern instead of the mental health grievance process. This process is called a request for a Fair (Administrative) Hearing. Your Ombuds can help you with the Fair Hearing process.

If you want to ask the Office of Administrative Hearings to review your complaint, you can send a request to:

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 985042

The toll-free telephone number is: 1-800-583-8271.

There are several local offices of OAH. Your case will be assigned to one near your home. If an in-person hearing is needed, it will be held in a location close to you.

Chelan-Douglas Regional Support Network

Serving Chelan and Douglas Counties

636 North Valley Mall Parkway, Suite 200
East Wenatchee, WA 98802-4875
Web: http://www.cdrsn.org

Toll Free: 1-877-563-3678
Public Phone: 509-886-6318
Ombuds Services: 1-800-495-5178
24-Hour Crisis Line: 1-800-852-2923

Authorized Community Mental Health Agencies	Phone
Catholic Family & Child Services 23 S. Wenatchee Avenue, Suite #320, Wenatchee, WA 98801-2263 *Alternative languages available: Spanish*	**509-622-6761**
Chelan-Douglas Behavioral Health Clinic 701 N. Miller Street, Wenatchee, WA 98801-2086 *Alternative languages available: Spanish*	**509-662-7195**
Children's Home Society 1014 Walla Walla Avenue, Wenatchee, WA 98801-1523 *Alternative languages available: Spanish*	**509-663-0034**

Clark County Regional Support Network

Serving Clark County

PO Box 5000
Vancouver, WA 98666-5000
Web: http://www.co.clark.wa.us/commserv/mental

Toll Free: 1-800-410-1910
Public Phone: 360-397-2130
Ombuds Services: (360) 694-6577x2233
24-Hour Crisis Line: 1-800-626-8137

Authorized Community Mental Health Agencies	Phone
Catholic Community Services 603 SE 116th Avenue, Vancouver, WA 98683-5257 *Alternative languages available: French, Russian and Spanish*	**360-260-6373**
Children's Center 415 W. 11th Street, Vancouver, WA 98666-0484 *Alternative languages available: Russian and Spanish*	**360-699-2244**
Children's Home Society 309 W. 12th Street, Vancouver, WA 98666-0605	**360-695-1325**
Columbia River Mental Health Services 6926 E. Fourth Plain Boulevard, Vancouver, WA 98661-7254 *Alternative languages available: Cambodian, Chinese, French, German, Igbo, Korean, Laotian, Russian, Spanish, Tagalog, Taiwanese and Vietnamese*	**360-993-3000**
Family Solutions 1104 Main Street, Suite 500, Vancouver, WA 98660-2972 *Alternative languages available: Spanish*	**360-695-0115**
Mental Health Northwest 1601 E 4th Plain Blvd, Bldg. A-8, Vancouver, WA 98668-1845	**360-906-8336**
Southwest Washington Medical Center 3400 Main Street, Vancouver, WA 98668-1600	**360-696-5300**

Grays Harbor Regional Support Network
Serving Grays Harbor County

2109 Sumner Avenue, Suite 203
Aberdeen, WA 98520-3699
Web: http://users.techline.com/ombuds/rsn.htm

Toll Free:	1-800-464-7277
Public Phone:	360-532-8665
Ombuds Services:	1-877-788-1782
24-Hour Crisis Line:	**1-800-685-6556**

Authorized Community Mental Health Agencies	Phone
Behavioral Health Resources 575 E. Main Street, Suite C, Elma, WA 98541-9551 *Alternative languages available: Spanish*	**360-482-5358**
Crisis Clinic 615 8th Street, Hoquim, WA 98550	**360-532-4357**
Evergreen Counseling Center 205 8th Street, Hoquiam, WA 98550-2507 *Alternative languages available: Spanish*	**360-532-8629**

Greater Columbia Behavioral Health Regional Support Network

Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman and Yakima Counties.
101 N. Edison Street
Kennewick, WA 99336-1958
Web: http://www.gcbh.org

Toll Free: 1-800-795-9296
Public Phone: 509-735-8681
Ombuds Services: 1-800-257-0660

24-Hour Crisis Lines:
Asotin: 888-475-5665
Benton-Franklin: 800-548-8761
Columbia: 800-734-9927
Garfield: 888-475-5665
Kittitas: 509-925-9861
Klickitat: 509-733-5801/800-572-8122
Skamania: 509-427-9488
Walla Walla: 509-522-4278
Whitman (collect): 509-334-1133
Yakima: 509-575-4200/800-572-8122
Children: 509-576-0934 or 800-671-5437

Authorized Community Mental Health Agencies	Phone
Benton/Franklin Counties Crisis Response Unit 2635 W. Deschutes Avenue, Kennewick, WA 99336-3004 *Alternative languages available: Spanish*	**509-783-0500**
Catholic Family and Child Services 5301 Tieton Drive, Suite "C", Yakima, WA 98908-3478 *Alternative languages available: Spanish*	**509-965-7100**
Central WA Comprehensive Mental Health (Yakima) 402 S. Fourth Avenue, Yakima, WA 98907-0959 *Alternative languages available: Spanish*	**509-575-4084**
Central WA Comprehensive Mental Health - Ellensburg 220 W. 4th Avenue, Ellensburg, WA 98926	509-025-9861
Central WA Comprehensive Mental Health – Toppenish 518 W. 1st Avenue, Toppenish, WA 98948	509-865-5898
Central WA Comprehensive Mental Health – Sunnyside 1319 Saul Road S., Sunnyside, WA 98944	509-837-2089
Central WA Comprehensive Mental Health – Goldendale 112 W. Main Street, Goldendale, WA 98620	509-773-5801
Central WA Comprehensive Mental Health - White Salmon 251 Rhine Village Drive, White Salmon, WA 98672	509-493-3400
Garfield County Human Services 856 W. Main Street, Pomeroy, WA 99347	**509-843-3791**
Inland Counseling Network (Walla Walla) 225 Woodland Ave, Walla Walla, WA 99362-3002	**509-525-0241**
Inland Counseling Network - Dayton 221 E. Washington Avenue, Dayton, WA 99328	**509-382-2527**
Inland Counseling Network - Dayton 213 W. Clay Street, Dayton, WA 99328	**509-382-2525**

Greater Columbia Behavioral Health RSN (Continued)

Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman and Yakima Counties.
101 N. Edison Street
Kennewick, WA 98336-1958
Web: http://www.gcbh.org

Toll Free: 1-800-795-9296
Public Phone: 509-735-8681
Ombuds Services: 1-800-257-0660

24-Hour Crisis Lines:
Asotin: 509-758-3341/758-4665
Benton-Franklin: 800-548-8761
Columbia: 509-382-2527
Garfield: 509-843-3791/843-1591
Kittitas: 509-925-9861
Klickitat:509-733-5801/800-235-4765
Skamania: 509-427-9488
Walla Walla: 509-522-4278
Whitman: 509-334-1133/332-1505
Yakima: 800-572-8122
Children: 509-576-0934 or 800-671-5437

Authorized Community Mental Health Agencies	Phone
Lourdes Counseling Center 1175 Carondelet Drive, Richland, WA 99352-3396 *Alternative languages available: Fijian, Hindi, Meman, Punjabi, Spanish and Urdu*	**509-943-9104**
Lutheran Community Services Northwest 3321 W. Kennewick Avenue, Suite 150, Kennewick, WA 99336-2959	**509-735-6446**
Nueva Esperanza Community Counseling Center - La Clinica 720 W. Court Street, Suite 8, Pasco, WA 99301-4178 *Alternative languages available: Spanish and Toisan*	**509-545-6506**
Palouse River Counseling Center 340 NE. Maple, Pullman, WA 99163	**509-334-1133**
Rogers Counseling Center 900 7th Street, Clarkston, WA 99403-2058	**509-758-3341**
Senior Solutions 5 W. Alder, Suite#328, Walla Walla, WA 99362	**509-527-0566**
Sunderland Family Treatment Services 8514 W. Gage Boulevard, Suite#301, Kennewick, WA 99336-8120	**509-736-0704**
Walla Walla County Crisis Response Unit **310 W. Poplar, Walla Walla, WA 99362** *Alternative languages available: Spanish*	**509-522-4278**
Yakima Valley Farmworkers Clinic Behavioral Health Services 918 E. Mead Avenue, Yakima, WA 98903-3720 *Alternative languages available: Spanish*	**509-453-1344**

King County Regional Support Network

Serving King County

821 2nd Avenue, Suite 610
Seattle, WA 98104-5019
Web: http://www.metrokc.gov/dchs/mhd/mhp/guide.htm

Toll Free:	1-800-790-8049
Public Phone:	206-296-5213
Ombuds Services:	1-800-790-8049
24-Hour Crisis Line:	**1-866-427-4747**

Authorized Community Mental Health Agencies	Phone
Asian Counseling & Referral Services 720 8th Avenue S. Suite 200, Seattle, WA 98104-3034 *Alternative languages available: Cambodian, Cantonese, French, H'mong, Ilocano, Japanese, Korean, Lao, Mandarin, Mien, Samoan, Tagalog, Thai, Taiwanese, Vietnamese and Visayan*	**206-695-7600**
Children's Hospital & Regional Medical Center 4800 Sand Point Way NE, Seattle, WA 98105-0371 *Alternative languages available: ASL*	**Front Desk: 206-987-2164** **Intake (New Patients Only): 206-987-2760**
Community House Mental Health 431 Boylston Avenue E., Seattle, WA 98102-4903 *Alternative languages available: Spanish*	**206-322-2387**
Community Psychiatric Clinic 4319 Stone Way N., Seattle, WA 98103-7490 *Alternative languages available: Chinese, French, German, Japanese, Spanish and Tagalog*	**206-461-3614**
Consejo Counseling & Referral Services 3808 S. Angeline Street, Seattle, WA 98118-1712 *Alternative languages available: Spanish*	**206-461-4880**
Downtown Emergency Service Center 507 - 3rd Avenue, Seattle, WA 98104- *Alternative languages available: Spanish*	**206-464-1570**
Evergreen Health Care 2414 SW Andover Street D-120, Seattle, WA 98106	**206-923-6300/1-800-548-0558**
Harborview Mental Health Services 325 9th Avenue, Seattle, WA 98104-2499 *Alternative languages available: French, Ilocano, Spanish and Tagalog*	**206-731-3411**
Highline/West Seattle Mental Health Center 2600 SW Holden Street, Seattle, WA 98168-1080 *Alternative languages available: Interpreters for any language available o request*	**206-248-8226**
Sea-Mar Community Health Center 8720 14th Avenue S., Seattle, WA 98108-4896 *Alternative languages available: Spanish*	**206-762-3730**
Seattle Children's Home 2142 10th Avenue W., Seattle, WA 98119-2899 *Alternative languages available: ASL, Greek, Spanish and Vietnamese*	**206-283-3300**
Seattle Counseling Service for Sexual Minorities 112 Broadway Avenue E, Seattle, WA 98102	**206-323-1768**

King County Regional Support Network (continued)

Serving King County

821 2nd Avenue, Suite 610
Seattle, WA 98104-5019

Toll Free:	1-800-790-8049
Public Phone:	206-296-5213
Ombuds Services:	1-800-790-8049
24-Hour Crisis Line:	**1-866-427-4747**

Authorized Community Mental Health Agencies	Phone

Seattle Mental Health — **206-324-0206**
1600 E. Olive St., Seattle, WA 98122-2799
Branches available in Bellevue, Auburn, and Renton
Alternative languages available: ASL, French, Gaelic, German, Hebrew, Hindi, Japanese, Mandarin, Russian, Spanish, Tagalog and Taiwanese

Therapeutic Health Service, Rainier Beach — **206-723-1980**
5802 Rainier Avenue S., Seattle, WA 98118-2706
Alternative languages available: Amharic, Cambodian, French, Japanese, Luthyia & Swahili

Valley Cities Counseling & Consultation — **253-939-4055**
2704 "I" Street NE, Auburn, WA 98002-2498
Alternative languages available: Czech, French, German, Punjabi, Russian and Spanish

YMCA Mental Health Services — **206-382-5340**
909 Fourth Avenue, Seattle, WA 98104

North Central Washington Regional Support Network

Serving Adams, Grant and Okanogan Counties.
131 Basin Street SW
Ephrata, WA 98823-1855

Toll Free:	1-800-251-5350
Public Phone:	509-754-6577
Ombuds Services:	1-800-346-4529

24-Hour Crisis Lines:
Adams (collect): 509-488-5611
Grant (collect): 509/765-1717/1-877-467-4303
Okanogan: 1-866-826-6191

Authorized Community Mental Health Agencies	Phone

Community Counseling Services of Adams County — **509-488-0244**
165 N. 1st Avenue, Suite 120, Othello, WA 99344-1003
Alternative languages available: Spanish

Grant Mental Healthcare — **360-765-9239**
840 East Plum Street, Moses Lake, WA 98837-0160
322 Fortuyn Road, Grand Coulee, WA 99133 — **509-633-1471**
Grand Coulee:
Moses Lake: 509-765-9239
Quincy: 509-787-4466
Alternative languages available: Spanish

Okanogan Behavioral Health Care — **509-826-6191**
107 W. Apple Street, Omak, WA 98841-3208
Alternative languages available: Spanish

North Sound Regional Support Network
Serving Island, San Juan, Skagit, Snohomish and Whatcom Counties.
117 N. 1st Street, Suite 8
Mount Vernon, WA 98273-2858
Web: http://www.nsrsn.org

Toll Free:	1-800-684-3555
Public Phone:	1-888-693-7200
Ombuds Services:	1-888-336-6164
24-Hour Crisis Line:	**1-800-584-3578**

Authorized Community Mental Health Agencies	Phone
Associated Provider Network	**1-888-693-7200**
Bridgeways **- 1220 75th Street SW, Everett, WA 98203**	
Catholic Community Services 1918 Everett Avenue, Everett, WA 98201-3607 *Alternative languages available: Spanish*	**360-676-2164**
Compass Health 4526 Federal Avenue, Everett, WA 98203-8810 *Alternative languages available: Spanish*	**(Island County) 360-419-3500**
	(San Juan County) 360-419-3500 **(Skagit County) 360-419-3500**
Alternative languages available: Cambodian and Spanish	
	(Snohomish County) 1-800-457-9303
Alternative languages available: Arabic, Cambodian, Cantonese, Czech, French, Mandarin, Russian, Slovak, Spanish and Ukrainian	
Sea Mar Counseling and Social Services 4455 Cordata Pkwy, Bellingham, WA 98226-8037	**Bellingham: 360-734-5458** **Everett: 425-347-5415** **Mount Vernon: 360-428-8912**
Alternative languages available: French and Spanish	
Volunteers of America 2802 Broadway, Everett, WA 98206-0839	**1-800-584-3578**
Whatcom Counseling & Psychiatric Clinic 3645 E. Mcleod Road, Bellingham, WA 98226-8799 *Alternative languages available: Spanish*	**360-676-2220**

Northeast Washington Regional Support Network
Serving Ferry, Lincoln, Pend Oreille and Stevens Counties.
PO Box 1249
Chewelah, WA 99109-1249

Toll Free: 1-800-201-4252
Public Phone: 509-935-6801
Ombuds Services: 1-800-735-7857
24-Hour Crisis Line: 1-800-767-6081

Authorized Community Mental Health Agencies	Phone
Ferry County Community Services 42 Klondike Road, Republic, WA 99166-9701	**509-775-3341**
Lincoln County Counseling Services 1211 Merriem Street, Davenport, WA 99122-0278 *Alternative languages available: Japanese and Spanish*	**509-725-3001**
Pend Oreille County Counseling Services 325 S. Washington Street, Newport, WA 99156-9671	**509-447-5651**
Stevens County Counseling Services 165 E. Hawthorne Avenue, Colville, WA 99114-2629	**509-684-4597**

Peninsula Regional Support Network
Serving Clallam, Jefferson and Kitsap Counties.

614 Division Street, MS 23
Port Orchard, WA 98366-4676

Toll Free: 1-800-525-5637
Public Phone: 360-337-4886
Ombuds Services: 1-888-377-8174
24-Hour Crisis Line: 1-800-843-4793
Kitsap County: (360) 479-3033
(800) 843-4793
East Jefferson County: (360) 385-0321
(800) 659-0321
East Clallam County: (360) 452-4500
West Jefferson County: (360) 374-5011
West Clallam County: (360) 374-5011
(Non-Business hours): (360) 374-6271

Authorized Community Mental Health Agencies	Phone
Jefferson Mental Health Services 884 West Park Avenue, Port Townsend, WA 98368-0565	**360-385-0321**
Kitsap Mental Health Services 5455 Almira Drive, Bremerton, WA 98311-8331 *Alternative languages available: Guatemalan, Japanese, Spanish and Tagalog*	**360-405-4010**
Peninsula Community Health Services 118 East 8th Street, Port Angeles, WA 98362-6129	**360-457-0431**
West End Outreach Services 530 Bogachiel Way, Forks, WA 98331-9120 *Alternative languages available: Spanish*	**360-374-5011**

Pierce County Regional Support Network
Serving Pierce County

3580 Pacific Avenue
Tacoma, WA 98418-7915
Web: http://www.co.pierce.wa.us/pc/services/health/mental/services.htm

Toll Free: 1-800-531-0508
Public Phone: 253-798-7202
Ombuds Services: 1-800-531-0508
24-Hour Crisis Line: 1-800-576-7764

Authorized Community Mental Health Agencies	**Phone**
Asian Counseling Services 4301 South Pine Street, Suite 405, Tacoma, WA 98409 *Alternative languages available: Many Asian Languages spoken*	**253-471-0141**
Catholic Community Services 5410 N. 44th Street, Tacoma, WA 98407-3799 *Alternative languages available: Cambodian, French, German, Korean, Lakota, Navajo, Nigerian, Romanian, Spanish and Swedish*	**253-759-9544**
Comprehensive Mental Health (Tacoma/Peninsula Area)	
514 S. 13th Street, Tacoma, WA 98402 (Adults/Older Adults)	**253-396-5000**
1201 S. Proctor Street, Suite 1, Tacoma, WA 98405-2095 (Children/Families) *Alternative languages available: ASL, Cantonese, Farsi, German, Greek, Hindi, Italian, Mandarin, Punjabi, Russian, Spanish, Tagalog, Ukrainian and Vietnamese*	**253-396-5800**
Crisis Intervention Teams	**Tacoma/Peninsula Area: 253-396-5089** **Lakewood/Southwest Pierce County Area: 253-584-8933** **Puyallup/East Pierce County Area: 253-584-8125 or 1-888-445-8125**
Good Samaritan Community Health Care (Puyallup/East Pierce County) 325 E. Pioneer, Puyallup, WA 98372-3265 *Alternative languages available: Cambodian, German, Korean, Spanish, Thai and Vietnamese*	**253-445-3120**
Greater Lakes Mental Healthcare (Lakewood/Southwest Pierce County) 9330 59th Avenue SW, Lakewood, WA 98499-6600 *Alternative languages available: ASL, Korean and Spanish*	**253-581-7020**
Kwawachee Counseling Center of the Puyallup Tribal Health Authority 2209 E. 32nd Street, Tacoma, WA 98404-4997	**253-593-0247**
Mobile Outreach Crisis Services	**253-798-2709**
Crisis Triage 3580 Pacific Avenue, Tacoma, WA 98418-7915	**253-798-4357**
Sea Mar Counseling and Social Services 1112 S. Cushman Avenue, Tacoma, WA 98405-3631 *Alternative languages available: Spanish*	**253-396-1634**

Southwest Regional Support Network
Serving Cowlitz County.

1952 9th Avenue
Longview, WA 98632-4045
Web: http://www.cowlitzcounty.org/humanservices/swrsn.htm

Toll Free: 1-800-803-8833
Public Phone: 1-800-803-8833
Ombuds Services: 360-501-6774
24-Hour Crisis Line: 1-800-803-8833

Authorized Community Mental Health Agencies	**Phone**
Center for Behavioral Solutions 600 Broadway, Longview, WA 98362 *Alternative languages available: Spanish*	**360-414-2280**
Lower Columbia Mental Health Center 1538 11th Avenue, Longview, WA 98632-4123 *Alternative languages available: Filipino, German, Russian and Spanish*	**360-423-0203**

Spokane County Regional Support Network
Serving Spokane County.
Monroe Court Building
901 N. Monroe Street, Suite 250
Spokane, WA 99201-2148
Web: http://www.spokanecounty.org/mentalhealth

Toll Free: 1-800-273-5864
Public Phone: 509-477-5722
Ombuds Services: 1-866-624-1740
24-Hour Crisis Line: 1-877-678-4428

Authorized Community Mental Health Agencies	**Phone**
Catholic Family Services 1023 W. Riverside Avenue, Spokane, WA 99210-1453	**509-358-4269**
Children's Home Society 920 North Argonne, Spokane, WA 99212-2722	**509-747-4174**
Family Service Spokane 7 S. Howard Street, Suite 321, Spokane, WA 99201-3816	**509-838-4128**
Grief Counseling Services 1016 N. Superior Street, Spokane, WA 99202-2059 *Alternative languages available: Spanish*	**509-238-6182**
Hope Partners/REM Associates 1117 West First Avenue, Spokane, WA 99201	**509-835-3599**
Lutheran Social Services NW 7 S. Howard Street, Suite #200, Spokane, WA 99201-3823 *Alternative languages available: ASL, French and Spanish*	**509-747-8224**
Spokane Mental Health 107 S. Division Street, Spokane, WA 99202-1586 *Alternative languages available: ASL, Cantonese, French, German, Mandarin, Russian, Spanish and Vietnamese*	**509-458-7453**
Spokane County Supportive Living Program 315 W. Mission Avenue, Suite #26, Spokane, WA 99201-2327 *Alternative languages available: Spanish*	**509-477-4386**
The N.A.T.I.V.E. Project 1803 W. Maxwell Avenue, Spokane, WA 99201-2831	**509-325-5502**

Thurston-Mason Regional Support Network
Serving Mason and Thurston Counties.

412 Lilly Road NE
Longview, WA 98506-5132

Toll Free:	1-800-624-1234
Public Phone:	360-786-5585
Ombuds Services:	1-800-624-1234 x2982
24-Hour Crisis Line:	**1-800-627-2211**

Authorized Community Mental Health Agencies	Phone
Behavioral Health Resources 317 Fourth Avenue E, Olympia, WA 98501-1191 *Alternative languages available: ASL, Cantonese, French, German, Mandarin, Russian, Spanish and Vietnamese.*	**360-704-7170**
South Sound Mental Health Services 6340 Capitol Boulevard S, Olympia, WA 98507-0677 *Alternative languages available: ASL, Cantonese, French, German, Mandarin, Russian, Spanish and Vietnamese.*	**360-754-7576**

Timberlands Regional Support Network
Serving Lewis, Pacific and Wahkiakum Counties.

PO Box 217
Cathlamet, WA 98612-0217

Toll Free:	1-800-392-6298
Public Phone:	360-795-3118
Ombuds Services:	1-866-322-1015

24-Hour Crisis Lines:
Lewis County: 1-800-559-6696
Pacific County: 1-800-884-2298
Wahkiakum County: 1-800-635-5989

Authorized Community Mental Health Agencies	Phone
Cascade Mental Health Care	
135 W. Main, Chehalis, WA 98532-0378	**360-748-6696/1-800-559-6696**
2428 Reynolds Avenues, Centralia, WA 98531 (Child & Adolescent Program)	**360-330-9044/1-800-559-6696**
Wahkiakum County Mental Health Services 42 Elochoman Valley Road, Cathlamet, WA 98612-9602	**360-795-8630/1-800-635-5989**
Willapa Counseling Center	
1107 North Pacific Hwy, Long Beach, WA 98631	**360-642-3787/1-800-884-2298**
819 Alder, South Bend, WA 98586	**360-895-9426/1-800-884-2298**

End of Attachment H.I.a.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item,

please explain why.

a. __X__ [Required] The State will ensure that materials provided to ~~potential enrollees and~~ enrollees by the State~~, the enrollment broker,~~ and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

The MHD makes the above information available at the first point of approval of Medicaid eligibility the Community Service Office (CSO), including the list of relevant contact information for both the state and the RSN. Additionally, in the letter received by each Medicaid enrolled individual from DSHS there is a paragraph explaining their mental health benefit and how to access mental health services. That section reads:" Mental illness affects many of us at some time in our lives. As a part of your Medicaid coverage, you can get mental health services such as: case management; therapy; medication management; hospitalization or crisis services, should you need them. Look in the phone book for crisis service numbers. Other mental health services are available to you through a Regional Support Network. Ask your worker how to contact them."

This information is again available through the Community Mental Health Agencies, the RSN offices, or through the Involuntary Detention process if this is their first contact with the mental health system, on the Mental Health Division's website and/or by calling the MHD's 1-800 number.

The PIHPs are required to provide supplemental information on significant benefit change directly to those consumers accessing mental health services. The notices will be updated in 2006.

b. __X__ ~~Potential enrollee and~~ enrollee materials will be translated into the prevalent languages listed below (If the State does not require written materials be translated, please explain):

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

1.__ Spoken by significant number of potential enrollees and enrollees .

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

3.__X__ Other (please explain):

The Department of Social and Health Services, the single state agency, identifies the following languages for translation.

Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese

c._X_[Required] Oral translation services are available to all ~~potential enrollees and~~ enrollees, regardless of languages.

d._X_ [Required] The State will have a mechanism in place to help enrollees ~~and potential enrollees~~ understand the managed care program. Please describe.

The state has produced the required informing materials for consumers and surveys consumers and stakeholder of their knowledge of managed care.

e._X_ [Required] Each MCO/PIHP will have a mechanism in place to help potential enrollees and enrollees understand the requirements and benefits of the plan. Please describe.

The state has produced the required informing materials for consumers. The PIHP is required to have more specific information with regards to authorization of services and level of care information in an easily understood format for consumers.

f._X_ The State's and MCO/PIHP/PAHP information materials are available *when requested* in alternative formats that takes into consideration the special needs of those, for example, with visual impairments.

II. Potential Enrollee Information

Not applicable under this waiver all Medicaid eligible are enrolled.

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a.___[Required] Timing. The State or its contractor will provide the required information:

(i) at the time the potential enrollee becomes eligible to enrollee in a voluntary program, or is first required to enrollee in a mandatory program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

b. Content The State and/or its enrollment broker provides the following information to potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation

describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2.___ An initial notification letter

3.___ A form for enrollment in the waiver program and selection of a plan

4.___ Comparative information about plans

5.___ Information on how to obtain counseling on choice of MCOs/PHPs

6.___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

7.__ A health risk assessment form to identify conditions requiring immediate attention.

8.__ [Required] General information about:
(i)__Basic features of managed care;
(ii)__Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment
(iii)__MCO/PIHP/PAHP responsibilities for coordination of care

9.__ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):
(i)__Benefits covered
(ii)__Cost sharing (if any)
(iii)__Service area
(iv)__ Names, locations, telephone numbers of, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals)
(v)__ Benefits available under state plan but not covered contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information.

10.__ Other items (please explain):

III. Enrollee Information

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

(i)**_X_** the State or its contractor
(ii)__ the MCO/PIHP/PAHP

b.__ [Required] Timing. The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as follows:

1.**_X_**For new enrollees, all required information *will be provided at the CSO with their enrollment package* .~~within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment~~.

2._X_ For existing enrollees:

(A) ~~State must notify of disenrollment rights at least annually, and if there is a lock-in, by no less than 60 days before the start of each enrollment period~~. N/A
(B) Notify all enrollees of right to request and obtain required information at least once a year.
(C) Provide written notice of any significant change in required information
(D) MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

(c)_X_[Required] Content: The State, its contractor, or the MCO/PIHP/PAHP will provide the following information to all enrollees:

(i)**_X_**Benefits covered
(ii)**_X_**Cost sharing
(iii)**_X_**Individual ~~provider~~ *CMHA* information -- name, location, telephone, non-English languages~~, not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals)~~

(iv)**_X_**Benefits available under state plan but not covered under contract, including conscience clause
(v)**_X_**Restrictions on freedom of choice within network
(vi)**_X_**Enrollee rights and protections
(vii)**_X_**Procedures for obtaining *mental health* benefits
(viii)**_X_**Extent to which benefits may be obtained out of network ~~(including family planning)~~
(ix)**_X_**Which and how after hours and ~~emergency~~ *crisis* care *per this waiver* are provided including

- ~~Definition of emergency medical condition, emergency services, and post-stabilization services~~
- ~~No prior authorization for emergency services~~
- Procedure for obtaining ~~emergency~~ *crisis* services *including crisis numbers*
- ~~Location of emergency settings~~
- ~~Right to use any hospital for emergency care~~

(x)__Post-stabilization rules
(xi)__Referral for specialty care
(xii)__[Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe to enrollees)
(xiii)_x State fair hearing rights

- Right to hearing
- Method for obtaining hearing
- Rules governing representation at hearing

(xiv) **X** MCO/PIHP grievance, appeal, and fair hearing procedures and timeframes, including :

- Right to file grievances and appeals
- Requirements and timeframes for filing grievance or appeal
- Availability of assistance in filing process
- Toll-free number to file grievance or appeal by phone
- Continuation of benefits, including
  - Right to have benefit continued during appeal or fair hearing
  - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee
- Any appeal rights State makes available to provider

(xv)**_X_** Advance directives for psychiatric care
(xvi)**_X_**Physician incentive plan information upon request
(xvii)**_X_**Information on structure/operation of plan, upon request

IV. Enrollee Rights:

Upcoming Waiver Period -- Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights. The State requires:

a._X_ [Required] MCOs/PIHPs to have written policies with respect to enrollee rights.

b._X_ [Required] Ensures staff and affiliated ~~providers~~ *CMHAs and their staff* take those rights into account when furnishing *mental health* services to enrollees

c._X_ [Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and Americans with Disabilities Act)

d._X_ [Required] The State will assure that each enrollee has the following rights:
(i)_X_ Receive information on their managed care plan
(ii)_X_ Be treated with respect, consideration of dignity and privacy
(iii)_X_ Receive information on *mental health* treatment options
(iv)_X_ Participate in decisions regarding care, including right to refuse treatment
(v)_X_ Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation
(vi)_X_ If privacy rules apply, request and receive copy of medical record and request amendments
(vii)_X_ Be furnished *mental* health care services in accordance with access and quality standards.

e._X_ [Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its providers treat the enrollee.

f.__ Other (please describe):

V. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint, item H.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

Enrollee rights in the public mental health system are found in many statutes and regulations, both state and federal. Rights are monitored both by the EQRO and the QA&I. Findings we addressed via corrective action plans. During this waiver period there was one fair hearing on rights for youth under 21 and 0 for adults.

Upcoming Waiver Period -- Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a.___ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b.___ The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.

c.___ The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):

d._X_ The State will monitor the MCO/PIHP/PAHPs compliance with the enrollee rights provisions in the following manner (please describe):

The MHD will continue to monitor using the mandatory protocols
.

Below are references that provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-

Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.