Facesheet: 1. Request Information (1 of 2)

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

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

Short title (nickname)	Long title	Type of Program
ICMH	Washington State Integrated Community Mental Health Program	PIHP;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Integrated Community Mental Health Program

C. Type of Request. This is an:

☑ **Renewal request.**

☑ **This is the first time the State is using this waiver format to renew an existing waiver.**

The renewal modifies (Sect/Part):

☑ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number (if applicable): WA.08.R08

Effective Date: *(mm/dd/yy)* 10/01/12

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

○ **1 year** ◉ **2 years** ○ **3 years** ○ **4 years** ○ **5 years**

Draft ID: WA.23.08.00
Waiver Number: WA.0008.R08.00

D. Effective Dates: This renewal is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: *(mm/dd/yy)*
10/01/12

Proposed End Date: 09/30/14
Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

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

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

Name:
Tom Gray

Phone: (360) 725-1314 **Ext:** ☐ **TTY**

Fax: (360) 725-2280

E-mail:

Tom.Gray@dshs.wa.gov

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

☐ **Washington State Integrated Community Mental Health Program**

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

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
The Department of Social and Health Services (DSHS), Aging and Disability Services Administration (ADSA) complies with Section 1902(a)(73) of the Social Security Act (the Act), and has met the Tribal Consultation Requirements under the Act as specified in the Washington State Medicaid State Plan, TN #11-25, effective July 1, 2011.

DSHS sent a notification of the tribal consultation to Tribal Leaders on 4-10-12. On 4-19-12, DSHS sent a follow-up letter with the Draft 1915(b) Waiver Renewal. The letters included:

-A request and due date for review and comment;

-a statement that the State anticipates that the impact to the tribes is the same as for other Medicaid recipients covered under the waiver;

-a statement that no State contracts with tribes will be impacted by the waiver renewal;

-a description of the purpose of the waiver renewal; and

-contact information for tribal questions.

DSHS engaged in a formal consultation on 5-31-12. The following was agreed to in the consultation:

-The waiver amendment effective 7-1-12, removing 1915(b)(3) funding for clubhouse, respite care, and supported employment will have a proportional impact on AI/AN people. The elimination of funding for these services should not impact services currently provided by tribal or urban Indian health programs.

DSHS committed to the development of a tribal centric mental health system that better serves the needs of the tribes. DSHS also acknowledged that separate mental health services are provided by facilities of the Indian Health Service under the Title XIX State Plan.

-DBHR held the first meeting in working toward this commitment on July 17, 2012, and the second meeting on August 7, 2012. Meetings are scheduled two times per month over the next six months, and will continue until all established goals are decided. The meetings include representatives from the tribes, DBHR tribal liaison staff, HCA Medicaid tribal liaison staff, the American Indian Health Commission, NW Portland Area Indian Health Board and DSHS Office of Indian Policy.

Four short term goals are being addressed:

*To ensure that the existing mental health system structure will support consistency in serving Medicaid eligible tribal members in obtaining all mental health services covered under the waiver and meet the contractually defined access and distance standards.
*To establish a DBHR 1-800 number for the tribes to use regarding any Access issues.
*To ensure understanding, availability, and how to access voluntary hospitalization authorization; and to ensure that all tribal

Medicaid enrollees know their Rights, with special emphasis on Appeal Rights.
*To establish a process for inclusion of tribal involvement in hospital discharge planning.

The long-term goal is to outline and define what a mental health program (tribal centric) should look like to benefit the tribes, with the cooperation of the RSNs

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
The former Mental Health Division (MHD) began delivering mental health services under a 1915(b) waiver in 1993, for outpatient mental health services and in 1997 for integrated community mental health. The first opportunity to demonstrate qualification and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks (RSNs). This opportunity was granted based on the RSNs agreement to enter into full-risk capitation contracts at actuarially sound rates. RSNs were also required to demonstrate capacity to meet program and fiscal requirements.

The State's Community Mental Health Services Act, RCW 71.24.030.(20) – Defines RSN as "a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region." RSNs administer funding appropriated by the Washington state legislature for both inpatient and outpatient mental health services. As Prepaid Inpatient Health Plans (PIHPs), the RSNs contract for direct services, provide utilization management and other administrative functions, and develop quality improvement and enrollee protections for all Medicaid clients enrolled in the RSN system. In Washington, 12 Regional Support Networks are comprised of county entities; the 13th – the Pierce County RSN – is operated by OptumHealth, a for- profit behavioral health entity.

The capitated managed mental health system gives the RSNs the ability to design an integrated system of mental health care; and, as necessary, subcontract with networks of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This contractual structure has improved mental health service outcomes and helped to control the rate of financial growth, while still requiring RSNs to adhere to all state and federal requirements. RSNs may impose additional requirements on subcontractors as needed to ensure appropriate management oversight and flexibility in addressing local needs.

The RSNs also work cooperatively with Healthy Options managed care organizations (MCOs) to ensure coordinated care for enrollees. Healthy Options is Washington's medical Medicaid-funded managed care program that serves TANF, SSI, and the Aged, Blind, and Disabled (presumptive SSI) enrollees. There are currently five managed care organizations under contract to cover a full array of medical services as well as a limited mental health benefit.

The state requires RSNs and Healthy Options MCOs to work cooperatively to manage enrollees receiving services from both systems in the most efficient and effective way possible. The RSNs and MCOs also coordinate to transition enrollees who have received the maximum mental health services under the benefit administered by the MCOs and are moving to the RSN managed mental health system to receive mental health care.

In mid-2009, the Mental Health Division was merged with the Division of Alcohol and Substance Abuse to form the Division of Behavioral Health and Recovery Services (DBHR). All program and policy functions are conducted by DBHR. 1915(b) Waiver development, administrative functions, RSN contracting, and external quality review were incorporated into DBHR.

Significant legislation, 2nd Engrossed 2SHB 1738 in 2011, transferred powers, duties, and functions of DSHS, pertaining to Medicaid medical assistance programs and the Medicaid Purchasing Administration to the State Health Care Authority (HCA). The bill required the Secretary of DSHS to enter into agreements with the Director of HCA in order to establish the division of responsibilities between the agencies with respect to mental health, chemical dependency, and long-term care services, including services for people with developmental disabilities. The change in the State Medicaid Agency from DSHS to HCA resulted in a cooperative agreement that states: "HCA as the single state Medicaid agency is responsible for approving rules, regulations, and policies that govern how the State Plan and waivers are operated. HCA and DSHS will work collaboratively in accordance with this Agreement, ensuring that HCA retains the authority to discharge its responsibilities for the administration of the Medicaid program pursuant to 42 CFR 431.10(e). Pursuant to 42 CFR 430.25, HCA delegates authority to DSHS to submit waiver applications, renewals and amendments to the federal Centers for Medicare and Medicaid Services (CMS). DSHS will provide HCA access to the application, renewal and/or amendment documents prior to submitting to CMS. DSHS will submit all necessary application, renewal, and amendment materials to CMS in order to secure and maintain approval of all proposed and existing waivers. DSHS has responsibility for the operation, management, and reporting of allowable Medicaid administrative activities for its approved federal waivers and State Plan options that require reporting."

On 5-31-12 DSHS participated in a formal Tribal Consultation. An agreement was reached that as part of the 1915(b)

ICMHP waiver, in accordance with Medicaid and Indian Health Care Improvement Act law and DSHS long-standing policy, AI/AN Medicaid beneficiaries and their clinical family members who are Medicaid beneficiaries are able to receive outpatient rehabilitative mental health services directly through Indian Health Services (IHS) operated clinics and 638 tribal clinics without having to be referred or screened by the ICMHP in their catchment area. IHS and tribal programs that are eligible will be reimbursed directly by the state's Medicaid program for providing these covered mental health services.

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 and integrated care for persons served by the public mental health system; and
3) Support recovery and reintegration to the community for persons with mental illness.

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.

The mission of DBHR is to administer a public mental health system that promotes recovery and resiliency as well as personal and public safety.

We are committed to taking action 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.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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

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

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

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

d. ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent

with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
-- *Specify Program Instance(s) applicable to this authority*
☑ **ICMH**

The 1915(b)(4) waiver applies to the following programs
☐ **MCO**
☑ **PIHP**
☐ **PAHP**
☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
☐ **FFS** Selective Contracting program

Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

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

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

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

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

-- *Specify Program Instance(s) applicable to this statute*
☑ **ICMH**

e. ☑ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
Section 438.52
Non-competitive Procurement - DBHR relies on the agreement with the Centers for Medicare and

Medicaid Services (CMS) that the Regional Support Networks (RSNs) have the first opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.

Pursuant to the State's Community Mental Health Services Act, RCW 71.24., which defines RSN as "a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region," county-based RSNs administer all community mental health services funded by the state. Additionally, 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 RCW 48.44 (the insurance code), as applicable.

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

Section 438.52 Choice – All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP covering a specific catchment area. The state requests authority to waive 438.52.
-- *Specify Program Instance(s) applicable to this statute*
☑ **ICMH**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

- ◉ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

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

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

- **The PAHP is paid on a risk basis**
- **The PAHP is paid on a non-risk basis**

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

e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- **the same as stipulated in the state plan**
- **different than stipulated in the state plan**

Please describe:

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

Procurement for MCO

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

Procurement for PIHP

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

The State has used a non-competitive procurement process. The State is in agreement with CMS that the Regional Support Networks (RSNs) have the first opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.

The State enters into a PIHP contract with the RSNs. If the RSN chooses not to participate, or is unable to meet required qualifications, DBHR will secure an alternate contractor. This would be facilitated as covered in the contingency plan submitted to CMS to avoid disruption of care for consumers.

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

Outpatient hospital services – PIHPs are responsible for community mental health rehabilitation services.

A subset of inpatient hospital services, mental health admissions –PIHPs are responsible for community mental health inpatient admissions.

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

Section A: Program Description

Part I: Program Overview

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

1. **Assurances.**

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

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

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

The State mandates enrollment into a single PIHP for each geographic area.

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

Program: " **Washington State Integrated Community Mental Health Program.** *"*

☐ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☑ **Other:**

please describe

Enrollees have the choice of mental health providers within their geographical RSN network area.

Section A: Program Description

Part I: Program Overview

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

3. **Rural Exception.**

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

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

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

Please define service area.

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

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

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

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*
     - [x] **ICMH**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     - [ ] **ICMH**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Counties - Chelan, Douglas	PIHP	Chelan-Douglas Regional Support Network
County - Clark	PIHP	Clark County Regional Support Network
County - Grays Harbor	PIHP	Grays Harbor Regional Support Network
11 Counties in Eastern Washington, listed separately in "Additional Information"	PIHP	Greater Columbia Behavioral Health Regional Support Network
County - King	PIHP	King County Regional Support Network
Counties - Adams, Grant, Okanogan, Stevens, Lincoln, Pend Oreille, Ferry	PIHP	North Central Regional Support Network
Counties - Skagit, San Juan, Island, Snohomish, Whatcom	PIHP	North Sound Regional Support Network
Counties - Clallam, Jefferson, Kitsap	PIHP	Peninsula Regional Support Network
County - Cowlitz	PIHP	Southwest Regional Support Network
County - Pierce	PIHP	OptumHealth - Pierce Regional Support Network
County - Spokane	PIHP	Spokane Regional Support Network
Counties - Thurston, Mason	PIHP	Thurston Mason Regional Support Network
Counties - Lewis, Pacific, Wahkiakum	PIHP	Timberlands Regional Support Network

Section A: Program Description

Part I: Program Overview

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

Additional Information. Please enter any additional information not included in previous pages:
Greater Columbia Behavioral Health Regional Support Network PIHP consists of counties Asotin, Garfield, Klickitat, Kittitas, Yakima, Benton, Franklin, Skamania, Walla Walla, Columbia, and Whitman.

The PIHP, Regional Support Networks listed in the geographic information represents the entire State of Washington. Within each PIHP, enrollees have their choice of providers.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

- [x] **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

- [x] **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
  - (•) **Mandatory enrollment**
  - ( ) **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Other** (Please define):

Individuals with serious and persistent mental illness and/or substance abuse.

Access to Care Standards at http://www.dshs.wa.gov/pdf/dbhr/mh/PI/Access_to_Care_Standards20060101.pdf, reflect 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 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.

According to 42 CFR 438 Section 2, Definitions, "Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician."

The above definition is specific to physical health providers – this waiver describes a managed care system for mental health services, thus the definition of health care professional has been modified in past waiver applications to include the definition of mental health professional.

In addition to the definition specified in 42 CFR 438.2, DBHR expanded the definition to include Mental Health Professional and mental health specialists, as defined in Washington State's Medicaid State Plan. This allows 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 allows the effective use of mental health professionals.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

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

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

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

- [x] **Reside in Nursing Facility or ICF/MR** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
- [ ] **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- [ ] **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- [ ] **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- [ ] **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- [ ] **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- [ ] **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- [ ] **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- [x] **Other** (Please define):

  Medicare Dual Eligibles Excluded have Medicare coverage, except for purposes of Medicaid-only services (pure QMB, pure SLMB, expanded SLMB, Qualified Disables and Working Individuals (QDWI)

  Medicaid coverage for women who are pregnant ends two months after the month in which the child is born if the women are not eligible for any other Medicaid program. These women are eligible for family planning services only. These services are not covered under this waiver, but are administered through the Health Care Authority (HCA).

  Other Excluded Populations -
  Other Special Needs Populations Including:
  -Homeless individuals for whom no Medicaid reimbursement is received
  -The following client groups are excluded from the capitation system and their mental health services are paid through other means:
  -Residents of state psychiatric hospitals;
  -Children in the Children's Long Term Inpatient Program;
  -Persons enrolled in the Program for All Inclusive Care for the Elderly (PACE) program; and
  -Persons enrolled in the Washington Medicaid Integration Partnership (WMIP). WMIP enrollees may "opt out" of the program and continue to receive mental health services from the Regional Support Network.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. **Assurances.**

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

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

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

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

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

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

Emergency Services Category General Comments (optional):
The PIHP does not cover emergency services. Medicaid enrollees have access to emergency services 24/7 independent of the Waiver.

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

- ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.
- ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
- ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.
- ☐ Other (please explain):
- ☑ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):
The PIHP does not cover family planning. Family planning is not a mental health service and is covered under HCA.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

- ☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- ☑ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:
  Currently there are FQHCs contracting for mental health services in the public mental health system. 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.
- ☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. **EPSDT Requirements.**

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

EPSDT Requirements Category General Comments (optional):
The PIHPs are required to submit the data as they would for any child being served according to the requirements of the data dictionary at http://www.dshs.wa.gov/pdf/dbhr/mh/mhrsndatadictionary2011.pdf. There is a simple data flag if the child is referred to services through an EPSDT screen. Of the 67,414 children served in the outpatient mental health system from April 1, 2009 through March 31, 2011, there were 14,252 unduplicated consumers flagged as being referred to mental health services via EPSDT.

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

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

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

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

1915(b)(3) Services Requirements Category General Comments:
This waiver includes no (b)(3) Services

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:
Each PIHP has an integrated crisis system, which is accessible 24 hours/7 days a week with responses from individuals, rather than recorded messages. This crisis system includes the following: crisis intervention; crisis respite; investigation and detention services; and, evaluation and treatment services.

Crisis response services are provided in the following manner:

* Toll free numbers that 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.
* Enrollees have unrestricted access to the crisis response system, without establishing medical necessity for the first contact, and without reference to the enrollee's ongoing service coverage under a particular RSN.
* Triage with local hospitals to reduce unnecessary utilization of the Emergency Department (ED) through working agreements with local evaluation and treatment facilities. The agreements ensure that enrollees who request mental health services inappropriately from the ED are directed to the crisis response system. The agreements also establish how people served in the ED may be referred for Designated Mental Health Professional evaluation for possible involuntary treatment. While ED visits not resulting in admission are not covered by this waiver, inpatient services for enrollees admitted through the ED are covered provided a designated mental health professional for the consumer's county of residence has conducted a pre-admission certification and conditions of medical necessity are met.
* PIHPs must report crisis services provided to the DBHR/CIS system. Crisis services are monitored by DBHR and the PIHPs on an ongoing basis. Additionally, the transition from crisis services to routine services is monitored to ensure compliance with Access to Care Standards. If a client accessing crisis response is already receiving services from the PIHP, access is required to the client's individual service plan on a 24/7 basis.

8. **Other.**

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

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

☑ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

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

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

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

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

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

Please describe the enrollment limits and how each is determined:

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

Please describe the State's standard:

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

Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

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

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

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

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

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

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

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

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

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

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

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

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

Please describe:

See Access to Care Standards at http://www.dshs.wa.gov/pdf/dbhr/mh/PI/Access_to_Care_Standards20060101.pdf on serving special needs populations of individuals with serious and persistent mental illness and/or substance abuse.

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

Please describe the enrollment limits and how each is determined:

*See Access to Care Standards at http://www.dshs.wa.gov/pdf/dbhr/mh/PI/Access_to_Care_Standards20060101.pdf on appropriate mental health care professionals.

*The State requires RSNs and Healthy Options Managed Care Organizations (MCOs) to work cooperatively to manage enrollees receiving services from both systems in the most efficient and effective way possible. The RSNs and MCOs also coordinate to transition enrollees who have received the maximum mental health services under the benefit administered by the MCOs and are transitioning to the RSN managed mental health system to receive mental health care.

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

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

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

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

Please describe:

1. It should be noted that in the context of Managed Mental Health services, the Mental Health Professional takes the place of the Primary Care Provider in developing a treatment plan. The treatment plan is developed collaboratively with the consumer and other people identified by the consumer as his or her support system. The treatment plan is developed within thirty days of starting community support services. The service plan should be in language and terminology that is easily understood by the consumer and his or her family, and include goals that are measurable.

2. The PIHP must have a written policy and procedure to ensure consistent application of requests within the service area. The PIHP must monitor the use and pattern of extensions and apply corrective action where necessary. Urgent and emergent medically necessary 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.

3. DBHR monitors services consistent with CMS requirements.

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

Please describe:

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

PIHPs are required to note primary health care providers (PCPs)in consumer files to refer consumers if needed. If consumers do not have a PCP, they are given information to obtain a PCP.

Section A: Program Description

Part II: Access

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

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

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

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

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

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

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

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

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

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the

practitioners, and documented in the primary care case manager's files.

i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

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

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
DBHR, through licensing review, monitors that treatment plans are being developed with the participation of the consumer and their natural support system. The team looks for quotes attributable to both the consumer and those whom they have identified as being an integral part of their treatment. DBHR requires the plan to be written in language and terminology easily understood by consumers. When reviewing treatment plans, the team also looks for abbreviations, overly complicated clinical descriptions, etc. The team reviews for documentation of coordination of services and consultation with children, geriatric, ethnic minority and disability mental health specialists.

The Mental Health Statistics Improvement Program (MHSIP) survey monitors satisfaction with participation in treatment and treatment planning. The survey results are at http://depts.washington.edu/washinst/.

The State requires the PIHP to coordinate health care services with other providers. This will continue to be monitored through the External Quality Review Organization (EQRO) protocols and by the Mental Health Licensing Team. Example list of provider types:

-Substance Abuse Providers
-Local Health Departments
-Dental Providers
-Transportation Providers
-HCBS (1915(c)) Service
-Developmental Disabilities
-Title V Providers
-Medical Providers
-Indian Health Services (IHS) operated programs, 638 tribally operated programs and urban Indian health programs.
-Other local service providers

RSNs work in partnership with a variety of other commuity agencies to coordinate care for 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 consumers' Mental Health Care Provider believes is necessary to complete or aid in the recovery process. ADSA, as part of the umbrella agency of DSHS, monitors coordination efforts through meetings with other divisions within the Department; works with the Indian Policy Advisory Committee; and, participates in stakeholder meetings with the Office of the Superintendent of Public Instruction and the Department of Health.

RSN contracts have the following coordination requirements:

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

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

*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.

*Maintain the relationship between the RSN and Healthy Option plans in the contracted service area through a Memorandum of Understanding.

*Maintain the relationship between the RSN and the DSHS Division of Vocational Rehabilitieation (DVR) office in the service area.

*Comply with published directives from DBHR when the RSN or its subcontractors are unable to resolve local disputes with other service systems (e.g. Healthy Options; other DSHS administrations) regarding service or cost responsibilities.

*RSNs are required to collaborate with tribal mental health providers to ensure coordination of services as well as appropriate placement of tribal consumers into inpatient treatment, as necessary. RSNs also coordinate with tribal mental health systems to ensure appropriate discharge planning from inpatient treatment facilities; and, are required to provide crisis services. In addition, the PIHP contracts can be updated as a result of agreements made through formal Consultation with the tribes. During the formal consultation with the tribes held 5-31-12, DSHS committed to the development of a tribal centric mental health system that better serves the needs of tribes.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

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

- ☑ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- ☑ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

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

  Section 1902(a)(4) is waived to permit the State to mandate beneficiaries into a single PIHP and restrict disenrollment.
- ☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- ☑ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that

contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:
12/01/03 *(mm/dd/yy)*

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

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

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	Acumentra Health	2011 to 2014	See comments	EDV

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

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

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

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following

(check all that apply):

A. ☐ Initial credentialing

B. ☐ Performance measures, including those obtained through the following (check all that apply):

- ☐ The utilization management system.
- ☐ The complaint and appeals system.
- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
Per Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, DBHR submitted to CMS a written strategy for assessing and improving the quality of managed care services offered by the PIHP on 12-1-03. An updated written strategy was submitted to CMS 5-31-07.

Annual independent external quality review of the outcomes and timelininess of, and access to the services delivered under the PIHP contract is conducted by Acumentra Health. Acumentra Health has a three year plan:

Year One: Compliance: Enrollee Rights and Grievance Appeal, PIP, PM; ISCA
Year Two: Compliance: QAPI and Program Integrity (follow up on prior year), PIP (follow up on prior year) PM: ISCA (follow up only)
Optional: EDV
Year Three: Compliance: follow up only on PIP, PM: ISCA, Quality Strategy

The State's current mental health system is administered via a managed care program; the standards for access and quality of services meet the same degree of rigor that is contanied in the State's Medicaid State Plan.

Section 438.52 - Non-competitive Procurement - DBHR relies on the previously mentioned agreement with CMS that the RSNs have the first opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.

Pursuant to the State's Community Mental Health Services Act, RCW 71.24, which defines RSN as "a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region," county-based RSNs administer all community mental health services funded by the State. Under the State's Involuntary Treatment Statues (RCW 71.05 and RCW 71.34), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Additionally, 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 RCW 48.44 (the insurance code), as applicable.

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- [x] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

  Because of mandatory enrollment into the RSN in a Medicaid enrollees' service area, there is no "marketing", as there is no choice of a different PIHP. DBHR provides the mental health benefits booklet for all Medicaid enrollees and the RSNs may or may not have additional information about their own services, but no marketing.
- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

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

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

   Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

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

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

   There are no potential enrollees. All Medicaid enrollees are enrolled into the RSN in their service area.
2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

   Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. ☐ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

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

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

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

Please describe the methodology for determining prevalent languages:

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

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
There is no marketing allowed, and DBHR provides information to all enrollees through the mental health benefits booklet or through other methods upon initial enrollment and yearly notification of rights.

All enrollee information is translated into Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese. The state agreement is that prevalent languages of at least 5% of the population must be translated. Only Spanish and Vietnamese languages meet this threshold.

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

Because of mandatory enrollment, there are no "potential" enrollees.

Translated languages include Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, Vietnamese. All Enrollee Information materials are translated into these eight languages.

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

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

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

Please explain how the State defines "significant.":

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

c. ☑ Other

Please explain:

DSHS defines "significant" population as 5% of the enrollee population. Some RSNs use this standard, however DBHR translates into eight languages.

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

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

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

Please describe:

Medicaid Enrollees receive an explanation of mental health managed care program through an attachment with the initial Approval Letter for benefits. This letter is issued through the Community Services Offices throughout the State. The mental health benefits booklet at http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml and is also offered at every intake and available online.

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- ☑ State
- ☑ Contractor

Please specify:

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

- ☑ the State
- ☑ State contractor

Please specify:

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

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

Section A: Program Description

Part IV: Program Operations

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

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

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. **Details**

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

a. **Outreach**

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

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

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

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

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

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

☐ This is a **new** program.

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

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

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

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

i. ☐ Potential enrollees will have ( ) **day(s)** / ( ) **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

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

☑ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☑ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

i. ☐ Enrollee submits request to State.

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

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

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

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

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

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

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

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
All Medicaid Recipients are automatically enrolled into the mental health managed care system in the RSN in their service area. The only way an enrollees' assigned RSN changes is if the enrollee moves into a different service area.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- [x] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

  The State has waived disenrollment rights.
- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- [x] The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting

programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

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

a. Direct Access to Fair Hearing

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

b. Timeframes

☑ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal**

is 20 days (between 20 and 90).

☑ The State's timeframe within which an enrollee must file a **grievance** is 99 days.

c. Special Needs

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

Please describe:

In previous waiver periods, the State negotiated with CMS to identify all Medicaid Enrollees with serious mental illness or children with a serious emotional disturbance as special needs clients and to treat these clients accordingly when providing mental health services through the PIHP system. Ombuds are available to assist all enrollees receiving care under the RSN mental health system.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

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

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

- ☐ the State
- ☐ the State's contractor.

Please identify:

- ☐ the PCCM
- ☐ the PAHP

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

Please describe:

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

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

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

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

☐ Has time frames for resolving requests for review.

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

☐ Establishes and maintains an expedited review process.

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

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
Section A. Part IV: Program Operations E. Grievance System Question 3.b. Timeframes:

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

-An enrollee may file a grievance with a telephone call or in writing. If the request is made through a telephone call, a follow up letter with the request must be completed within seven days.

-The CMHA or RSN must tell the enrollee by telephone or send a letter to the enrollee within one working day as notification of receipt of the request for a grievance. If the enrollee is informed by telephone, the CMHA or RSN must also send a letter within five working days.

-If the process is started at the CMHA level, and the enrollee is not happy with the CMHA decision, they have five calendar days from receipt of the written CMHA decision to take the grievance to the level of the RSN.

-There are timelines that must be followed by the CMHA and the RSN. Normally this is 30 days from the time an enrollee makes the request. An enrollee may ask for an additional 14 calendar days for the RSN to respond, or the RSN may ask for an additional 14 days to make a decision if more information is needed. The request for more time must be in the enrollee's best interest. The request for the additional time must state the reason for the request.

-The enrollee will receive a letter from the RSN with the decision about the grievance prior to the expiration of the additional requested time, or 30 days from the initial request if no additional time is requested.

-If an enrollee does not receive a letter within the timeframes in the rules, or the enrollee disagrees with the RSN decision, a request for an administrative (fair) hearing may be requested.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

- ☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:
  1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
  2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

  The prohibited relationships are:
  1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
  2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
  3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
- ☑ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
  1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
  2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
  3. Employs or contracts directly or indirectly with an individual or entity that is
     a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
     b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

- ☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- ☑ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
- ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Each RSN is paid a Per Member Per Month (PMPM) for Medicaid Enrollees in their service area. Encounter Data is submitted from the RSNs and is ertified and validated both internally and by Acumentra Health.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☑ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other						

	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines			

	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☑ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☑ PIHP ☐ PAHP

	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
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Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☑ PIHP	☐ MCO ☑ PIHP	☐ MCO ☐ PIHP

	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Profile Utilization by Provider Caseload	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☑ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
ICMH	PIHP;

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

Part II: Details of Monitoring Activities

Program Instance: Washington State Integrated Community Mental Health Program

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

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

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

Activity Details:

Acumentra Health, Inc. (EQRO Contractor/Q.I.O.)
The EQRO monitors for all 42 CFR 438 activities using the CMS protocol. Compliance with Performance Measures and PIPs (clinical and non-clinical) are completed yearly. Compliance with QAPI and Program Integrity are completed every three years. Encounter Data Validation (EDV)is completed every other year, and the Quality Strategy, developed in partnership with HCA and DBHR will be reviewed in 2013.

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

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☑ **Other**

Please describe:
EQRO Contractor/Q.I.O.

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

Activity Details:

Same information as in B.II.a. above.

Department of Health and DBHR Department of Licensing and Certification also monitor inidividual provider eligibility to participate as a Medicaid provider.

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☑ **Other**

Please describe:
EQRO Contractor/Q.I.O.

c. ☑ **Consumer Self-Report data**

Activity Details:

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

☐ **CAHPS**

Please identify which one(s):

☑ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:

EQRO monitors Encounter Data Validation (EDV)

Grievance, Appeals, and Fair Hearing Data is also monitored as indicators of potential issues that need to be addressed more formally.

- [ ] **Denials of referral requests**
- [ ] **Disenrollment requests by enrollee**
  - [ ] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [ ] **Other**

Please describe:

e. [x] **Enrollee Hotlines**

Activity Details:
DBHR Contract Monitoring staff ensure the provision of 24/7 hotlines in each RSN service area in three different areas:
*EQRO audits the RSNs to ensure RSNs monitor for the provision of 24/7 hotlines in their service area.
*DBHR contract monitoring staff ensure the accuracy and provision of the RSN 24/7 hotlines annually when updating the Mental Health Benefits Booklet and the DBHR website.
*DBHR contract staff make random calls to the RSN posted 24/7 hotline numbers to ensure the number is answered according to the PIHP Contract.

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

Activity Details:
Acumentra Health completed a Focused Study in January of 2011. The results are at http://www.dshs.wa.gov/pdf/dbhr/mh/mhprioritystandardseqroreport012011.pdf.

g. [ ] **Geographic mapping**

Activity Details:

h. [ ] **Independent Assessment** (Required for first two waiver periods)

Activity Details:

i. [x] **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:
The EQRO monitors for all 42 CFR 438 activities using the CMS protocol.

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

Activity Details:
DBHR Contract Monitoring Staff and Acumentra Health ensure provider adequacy through yearly on-site visits, ratio of population in service area, and availability of providers within the RSN service area to assist non-English speaking residents.

k. [x] **Ombudsman**

Activity Details:
PIHP contract requires the use of Ombudsman and contact informtion is available through the RSN's subcontractor or the mental health benefit booklet.

l. ☑ **On-Site Review**

Activity Details:
DBHR Licensing Staff, Contract Monitoring, and Acumentra Health complete on-site reviews yearly to ensure contracts, clients rights, licensing and cerification issues, and 42 CFR 438 requirements are met by each PIHP, RSN, and their subcontractors.

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

Activity Details:
Acumentra Health, Inc. (EQRO Contractor/Q.I.O.)
The EQRO monitors for all 42 CFR 438 activities using the CMS protocol. Compliance with Performance Measures and PIPs (clinical and non-clinical) are completed yearly. Compliance with QAPI and Program Integrity are completed every three years. Encounter Data Validation (EDV)is completed every other year, and the Quality Strategy, developed in partnership with HCA and DBHR will be reviewed in 2013.

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

- ☑ **Clinical**
- ☑ **Non-clinical**

n. ☑ **Performance Measures** [Required for MCO/PIHP]

Activity Details:
Acumentra Health, Inc. (EQRO Contractor/Q.I.O.)
The EQRO monitors for all 42 CFR 438 activities using the CMS protocol. Compliance with Performance Measures and PIPs (clinical and non-clinical) are completed yearly. Compliance with QAPI and Program Integrity are completed every three years. Encounter Data Validation (EDV)is completed every other year, and the Quality Strategy, developed in partnership with HCA and DBHR will be reviewed in 2013.

Individual PIHP reports are submitted to the State every year as well as a State-wide report. The State-wide report is submitted to CMS yearly in December to January. Corrective action established by Contract Monitoring is also checked annually or by the use of "deliverables" to verify improvement in identified areas if needed.

- ☑ **Process**
- ☑ **Health status/ outcomes**
- ☑ **Access/ availability of care**
- ☑ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☑ **Periodic Comparison of # of Providers**

Activity Details:
Acumentra Health through EQRO and Contract Monitoring staff ensure that the population in the RSN service area is served adequately by the number of providers subcontracted through the RSNs' Community Mental Health Agencies (CMHAs)

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

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

Survey of providers

Focus groups

r. Test 24/7 PCP Availability

Activity Details:
Contract Monitoring ensures annually that each service area has adequate capacity of 24/7 availability. In addition, crisis services are available 24/7 without the need for an intake.

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

Activity Details:

t. Other

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

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

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

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

The Monitoring Activities were conducted as described:

(●) **Yes** ( ) **No**

If No, please explain:

Provide the results of the monitoring activities:

DBHR monitors services in a variety of ways. In addition to the annual on-site monitoring activities of the EQRO,DBHR contract monitoring staff, and licensing and cerfication activities, there are the meetings with stakeholders on a regular basis, additional monitoring of performance indicators through the Information System, monitoring of complaints and grievances, and satisfaction surveys. Medicaid Enrollees filing Grievance, Appeal, and Fair Hearings also provide a way to monitor service and data is utilized to ensure quality of care.

The 2009 EQRO report was submitted to CMS Region X in December 2009. The report can be accessed at http://dshs.wa.gov/dbhr/mhreports.shtml. A performance indicator report may be found at http://www.mhd-pi.com/.

DBHR regularly conducts child and adult satisfaction surveys as well as provider surveys to assess the use of evidence based services. Results of current and past consumber and provider surveys may be found at http://depts.washington.edu/washinst/Reports/Reports.html.

In addition, EQRO, through Acumentra, has the following scope of work:

*conducting a monitoring review to determine PIHP compliance with CMS Protocols;
*annual validation of PIHP Performance Improvement Projects (PIPs) and Performance Measures (PMs);
*annual Encounter Data Validation;
*completion of an information System Capability Assessment (ISCA);
*review of the combined HCA/ADSA Quality Strategy
*yearly technical assistance and training in areas identified for performance improvement at the state and/or PIHP level;

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2010	09/30/2011	10/01/2011	03/31/2012
Enrollment Projections for the Time Period*	10/01/2012	09/30/2013	10/01/2013	09/30/2014

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

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

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Inpatient Hospital - Psych (other than in IMDs)	☑	☐	☑	
Outpatient Hospital Services (other than Lab & X-ray)	☑	☐	☐	
Rural Health Clinic Services (Included in Waiver Cost only if contracted to	☑	☐	☑	

provide)			
Federally Qualified Health Center Services (Included in Waiver Cost if contracted to provide)	☑	☐	☑
Department-approved Alcohol/Drug Treatment Centers Fee-for-Service Reimbursment	☑	☐	☐
Professional & Clinic & other Lab and X-ray (ITA - Fee for Service)	☑	☐	☐
EPSDT (Including Chiropractic) - Mental Health Services only covered under Waiver Costs	☑	☐	☑
Physicians' Services (Psychiatrist) - Fee for Service	☑	☐	☐
Other Practioners' Services (Psychologists) - Fee for Service	☑	☐	☐
Prescribed Medications (Pharmacy) - Fee for Service	☑	☐	☐
Detoxification - Fee for Service	☑	☐	☐
Mental Health Service (MHS), Brief Intervention Treatment	☑	☐	☑
MHS - Crisis Services	☑	☐	☑
MHS - Day Support	☑	☐	☑
MHS - Family Treatment	☑	☐	☑
MHS - Freestanding Evaluation and Treatment	☑	☐	☑
MHS - Group Treatment Services	☑	☐	☑
MHS - High Intensity Treatmeent	☑	☐	☑
MHS - Intake Evaluation	☑	☐	☑
MHS - Medication Management	☑	☐	☑
MHS - Medication Monitoring	☑	☐	☑
MHS - Provided in Residential Settings	☑	☐	☑
MHS - Peer Support	☑	☐	☑
MHS - Psychological Assessment	☑	☐	☑
MHS - Rehabilitation Case Management	☑	☐	☑
MHS - Special Population Evaluation	☑	☐	☑
MHS - Stabilization Services	☑	☐	☑
MHS - Therapeutic Psychoeducation	☑	☐	☑
MHS - Supported Employment (Eliminated eff. 7-1-12)	☐	☑	☐
MHS - Respite Care (Eliminated eff. 7-1-12)	☐	☑	☐
MHS - Mental Health Clubhouse (Eliminated eff. 7-1-12)	☐	☑	☐
Behavioral Rehabilitation Services - Fee for Service	☑	☐	☐

IMD Services for Age 65 and Older	☑	☐	☑
Inpatient Psychiatric Services (Age under 21 years) - CLIP Fee for Service	☑	☐	☑
Psychologists (May be covered either by Fee-for-Service or through MCO, depends on referral process	☑	☐	☑
	☐	☐	☐
	☐	☐	☐
Inpatient Hospital	☑	☐	☐
Other Lab & X-ray Services	☑	☐	☐
Medical & Surgical Services Performed by a Dentist	☑	☐	☐
Podiatrists' Services	☑	☐	☐
Vision Care Services and Eyeglasses	☑	☐	☐
Licensed midwives and Nurse midwives	☑	☐	☐
Home Health Care Services	☑	☐	☐
Private Duty Nursing Services	☑	☐	☐
Clinic Services - Freestanding Kidney Centers Chronic Dialysis Services	☑	☐	☐
Dental Services	☑	☐	☐
Physical Therapy	☑	☐	☐
Occupational Therapy	☑	☐	☐
Speech Therapy	☑	☐	☐
Dentures	☑	☐	☐
Durable Medical Equipment including Prosthetic Devices (except Hearing Aides)	☑	☐	☐
Hearing Aids	☑	☐	☐
Preventative Services	☑	☐	☐
Rehabilitation Treatment Services	☑	☐	☐
Nurse Midwife	☑	☐	☐
Education Agency Services (School-Based Services for Special Education Program)	☑	☐	☐
Family Preservation Services	☑	☐	☐
Private Duty Nursing	☑	☐	☐
Freestanding Birth Centers	☑	☐	☐
Intermediate Care Facility Services (other than an IMD)	☑	☐	☐
Intermediate Care Facility Services (In an IMD)	☑	☐	☐
Developmental Disabilities Services			

(ICF/MR), medical services Fee-for-Service through ICF/MR	☑	☐	☐
Hospice	☑	☐	☐
Targeted Case Management Services	☑	☐	☐
Extended Services for Pregnant Women	☑	☐	☐
Family Planning Services	☑	☐	☐
Obstetrical Services	☑	☐	☐
Respiratory Care	☑	☐	☐
Certified Pediatric or Family Nurse Practitioner Services	☑	☐	☐
Transportation	☑	☐	☐
Skilled Nursing Facility Services (age under 21 years)	☑	☐	☐
Emergency Services (is an outpatient hospital service)	☑	☐	☐
Personal Care	☑	☐	☐
PACE	☑	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature:	MaryAnne Lindeblad
	State Medicaid Director or Designee
Submission Date:	Aug 29, 2012

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

b. Name of Medicaid Financial Officer making these assurances:

Melissa M. Clarey

c. Telephone Number:

(360) 725-1675

d. E-mail:

Melissa.Clarey@dshs.wa.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

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

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- **a.** [ ] **MCO**
- **b.** [x] **PIHP**
- **c.** [ ] **PAHP**

d. ☐ **PCCM**

e. ☐ **Other**

Please describe:

See A.I.b.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

The management fees were calculated as follows.

1. ☐ **Year 1: $** _____ **per member per month fee.**
2. ☐ **Year 2: $** _____ **per member per month fee.**
3. ☐ **Year 3: $** _____ **per member per month fee.**
4. ☐ **Year 4: $** _____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**

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

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

d. ☐ **Other reimbursement method/amount.**

$ _____

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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

b. ☑ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

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

or over time:

The caseload forecasts for Medicaid eligible people are created by the Caseload Forecast Council. They are created for each eligibility group. The primary distinctions are Categorically Needy: Grant-Receiving Adults and Children, Non-Grant Pregnant Women, Non-Grant Children, SSI and SSI-Related; Medically Needy: Aged and Disabled; and State-Funded Medical Care Services. 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. This forecast does not currently include the Medicaid expansion population effective January 2014 related to the Affordable Care Act. A future amendment will be submitted if necessary.

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

There are no other variances in the member month projections.

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

R1 is FFY 2011 quarter 1 through FFY 2011 quarter 4 (10/11 – 9/11) and R2 is FFY 2012 quarter 1 through FFY 2012 quarter 2 (10/11 – 3/12).

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

a. **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**

Explain the differences here and how the adjustments were made on Appendix D5:

Effective 7-1-12, the State will no longer provide services under 1915(b)(3) authority. Because the time period from October 2011 through March 2012 was used as basis for projecting waiver costs, expenses associated with 1915(b)(3) services needed to be removed. The methodology for this adjustment is discussed in this preprint. 1915(b)(3) services are in the actual waiver costs as well as certain reported costs related to MCO capitation payments on line 18A and certain physician supplemental payments reported on line 5B. Adjustments were made on D5 to remove these costs from the 1915(b)(3) and State Plan projections.

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

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

For mental health-related services, only state-only funded services are not included in the analysis. WA used audited CMS 64 waiver reports for the basis of the analysis. As a result of discussions with CMS, costs for additional services not initially reported on the CMS 64 waiver reports have been added to Appendix D3. These additional costs are discussed later in this preprint.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Inpatient Hospital - Psych (other than in IMDs)	☐	☐	☐	☑	☐	☐	☐
Outpatient							

Hospital Services (other than Lab & X-ray)	☐	☐	☐	☐	☐	☐	☐
Rural Health Clinic Services (Included in Waiver Cost only if contracted to provide)	☐	☐	☐	☑	☐	☐	☐
Federally Qualified Health Center Services (Included in Waiver Cost if contracted to provide)	☐	☐	☐	☑	☐	☐	☐
Department-approved Alcohol/Drug Treatment Centers Fee-for-Service Reimbursment	☐	☐	☐	☐	☐	☐	☐
Professional & Clinic & other Lab and X-ray (ITA - Fee for Service)	☐	☐	☐	☐	☐	☐	☐
EPSDT (Including Chiropractic) - Mental Health Services only covered under Waiver Costs	☐	☐	☐	☑	☐	☐	☐
Physicians' Services (Psychiatrist) - Fee for Service	☐	☐	☐	☐	☐	☐	☐
Other Practioners' Services (Psychologists) - Fee for Service	☐	☐	☐	☐	☐	☐	☐
Prescribed Medications (Pharmacy) - Fee for Service	☐	☐	☐	☐	☐	☐	☐
Detoxification - Fee for Service	☐	☐	☐	☐	☐	☐	☐
Mental Health Service (MHS), Brief Intervention Treatment	☐	☐	☐	☑	☐	☐	☐
MHS - Crisis Services	☐	☐	☐	☑	☐	☐	☐
MHS - Day Support	☐	☐	☐	☑	☐	☐	☐

MHS - Family Treatment	☐	☐	☐	☑	☐	☐	☐
MHS - Freestanding Evaluation and Treatment	☐	☐	☐	☑	☐	☐	☐
MHS - Group Treatment Services	☐	☐	☐	☑	☐	☐	☐
MHS - High Intensity Treatmeent	☐	☐	☐	☑	☐	☐	☐
MHS - Intake Evaluation	☐	☐	☐	☑	☐	☐	☐
MHS - Medication Management	☐	☐	☐	☑	☐	☐	☐
MHS - Medication Monitoring	☐	☐	☐	☑	☐	☐	☐
MHS - Provided in Residential Settings	☐	☐	☐	☑	☐	☐	☐
MHS - Peer Support	☐	☐	☐	☑	☐	☐	☐
MHS - Psychological Assessment	☐	☐	☐	☑	☐	☐	☐
MHS - Rehabilitation Case Management	☐	☐	☐	☑	☐	☐	☐
MHS - Special Population Evaluation	☐	☐	☐	☑	☐	☐	☐
MHS - Stabilization Services	☐	☐	☐	☑	☐	☐	☐
MHS - Therapeutic Psychoeducation	☐	☐	☐	☑	☐	☐	☐
MHS - Supported Employment (Eliminated eff. 7-1-12)	☐	☐	☐	☐	☐	☐	☐
MHS - Respite Care (Eliminated eff. 7-1-12)	☐	☐	☐	☐	☐	☐	☐
MHS - Mental Health Clubhouse (Eliminated eff. 7-1-12)	☐	☐	☐	☐	☐	☐	☐
Behavioral Rehabilitation Services - Fee for Service	☐	☐	☐	☐	☐	☐	☐

IMD Services for Age 65 and Older	☐	☐	☐	☑	☐	☐	☐
Inpatient Psychiatric Services (Age under 21 years) - CLIP Fee for Service	☐	☐	☐	☑	☐	☐	☐
Psychologists (May be covered either by Fee-for-Service or through MCO, depends on referral process	☐	☐	☐	☑	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
Inpatient Hospital	☐	☐	☐	☐	☐	☐	☐
Other Lab & X-ray Services	☐	☐	☐	☐	☐	☐	☐
Medical & Surgical Services Performed by a Dentist	☐	☐	☐	☐	☐	☐	☐
Podiatrists' Services	☐	☐	☐	☐	☐	☐	☐
Vision Care Services and Eyeglasses	☐	☐	☐	☐	☐	☐	☐
Licensed midwives and Nurse midwives	☐	☐	☐	☐	☐	☐	☐
Home Health Care Services	☐	☐	☐	☐	☐	☐	☐
Private Duty Nursing Services	☐	☐	☐	☐	☐	☐	☐
Clinic Services - Freestanding Kidney Centers Chronic Dialysis Services	☐	☐	☐	☐	☐	☐	☐
Dental Services	☐	☐	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐	☐
Speech Therapy	☐	☐	☐	☐	☐	☐	☐
Dentures	☐	☐	☐	☐	☐	☐	☐
Durable Medical Equipment including Prosthetic	☐	☐	☐	☐	☐	☐	☐

Devices (except Hearing Aides)							
Hearing Aids	☐	☐	☐	☐	☐	☐	☐
Preventative Services	☐	☐	☐	☐	☐	☐	☐
Rehabilitation Treatment Services	☐	☐	☐	☐	☐	☐	☐
Nurse Midwife	☐	☐	☐	☐	☐	☐	☐
Education Agency Services (School-Based Services for Special Education Program)	☐	☐	☐	☐	☐	☐	☐
Family Preservation Services	☐	☐	☐	☐	☐	☐	☐
Private Duty Nursing	☐	☐	☐	☐	☐	☐	☐
Freestanding Birth Centers	☐	☐	☐	☐	☐	☐	☐
Intermediate Care Facility Services (other than an IMD)	☐	☐	☐	☐	☐	☐	☐
Intermediate Care Facility Services (In an IMD)	☐	☐	☐	☐	☐	☐	☐
Developmental Disabilities Services (ICF/MR), medical services Fee-for-Service through ICF/MR	☐	☐	☐	☐	☐	☐	☐
Hospice	☐	☐	☐	☐	☐	☐	☐
Targeted Case Management Services	☐	☐	☐	☐	☐	☐	☐
Extended Services for Pregnant Women	☐	☐	☐	☐	☐	☐	☐
Family Planning Services	☐	☐	☐	☐	☐	☐	☐
Obstetrical Services	☐	☐	☐	☐	☐	☐	☐
Respiratory Care	☐	☐	☐	☐	☐	☐	☐
Certified Pediatric or Family Nurse Practitioner Services	☐	☐	☐	☐	☐	☐	☐

Transportation	☐	☐	☐	☐	☐	☐	☐
Skilled Nursing Facility Services (age under 21 years)	☐	☐	☐	☐	☐	☐	☐
Emergency Services (is an outpatient hospital service)	☐	☐	☐	☐	☐	☐	☐
Personal Care	☐	☐	☐	☐	☐	☐	☐
PACE	☐	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

Please explain:

The administrative costs reflected on Appendix D3 are pulled directly from the CMS 64.10 waiver forms. These expenses are for specific contracts or allocated staff working directly on the RSN waiver program. In addition, the State identified expenses for the EQRO contractor, CLIP administration, and actuarial contracts that were inadvertently left off the waiver report. These expenses have been identified and included in the reported waiver expenses in column K of Appendix D3.

Previously, CMS and the State have discussed which service expenses should be reported against the WA PIHP waiver. Final decisions were made and a subsequent waiver amendment was submitted July 1, 2009. While the State has continued to incorporate the reporting of the agreed upon services on prospective CMS 64 waiver forms, the historical expenses captured on the waiver schedules (and available in the MBES system) are slightly understated. As a result, the State worked with Mercer to identify all applicable waiver-related expenses to reflect on Appendix D.3.
Mercer began by summarizing actual waiver service costs reported directly on CMS 64 waiver forms. These expenses are captured in columns D,E, H, I, and J on Appendix D.3. In addition, Mercer worked with the State to identify certain additional services costs that should have been reported against the waiver which were agreed to in prior State discussions with CMS. As the State did not retroactively adjust CMS 64 reporting, the following costs (not reflected on the CMS 64 forms) have been added to the retrospective periods in column F (services) and column K (admin) of Appendix D3.
Additionally, all pharmacy expenses for FFY2011 Q1 and Q2 were reported against the non-disabled waiver. To accurately reflect the distribution of pharmacy spend, Mercer used the historic pharmacy spend distribution of roughly 80% disabled / 20% non-disabled to reallocate. This results in $50,199,169 in pharmacy dollars moved from the non-disabled MEG into the disabled MEG for the R1 period.

Behavioral Health Expense Program	Subprogram/Sub-Object	Costs Added to R1	Costs Added to R2
Certain Pharmacy	080 M411	-$217,287	-$11

Certain Psychiatry	080 M311	-$44	$0	
Drug and Alcohol Substance Abuse	070, All	$1,382,317	$661,188	
CLIP Administration		$243,758	$121,335	
Community Psychiatry		$250,364	$0	
EQRO (Admin)		$1,505,228	$545,202	
Salaries (Actuarial / Other)		$259,168	$126,589	

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

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

☐ **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:

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

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

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

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

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

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

   Document

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

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

Document:

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

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative

if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

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

   The actual trend rate used is: 1.60

   Please document how that trend was calculated:

   From the end of R2 to the beginning of P1, trends were reviewed for capitated, BH pharmacy and FFS wraparound services. For capitated services, Mercer used the actual annual trend rate of 2.4% used to develop the WA PIHP capitation rates for calendar year (CY) 2012. These are consistent with the capitation trend inflation apparent between R1 and R2. Pharmacy and other FFS wraparound utilization have continually been managed by the state resulting in low and even negative historic trends. Therefore Mercer has assumed flat inflation of these services for the period between R2 and P1. The resulting blended trend rate used for the period between R2 and P1 is 1.6%

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

   i. **State historical cost increases.**

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

   The base period for developing the waiver projections is October 1, 2011 through March 31, 2012.

   Mercer considers historical year over year trends, as well as rolling averages in making these estimates.

   For base periods R1 and R2, the PIHP capitated service trend indicates roughly 3.3% annual trend while BH pharmacy and FFS wraparound service trends show negative growth rates. This waiver cost trend has been managed to a very low rate of growth over the past two years through the utilization management of services. For the waiver projection, Mercer incorporated additional trend analyses from the actuarial rate development and quarterly analysis of FFS trends.

   For capitated services, Mercer used a trend rate consistent with the actuarial rate development for CY2012 which is 2.4%. As mentioned above, utilization for BH pharmacy and FFS wraparound services have been managed to a very low and even negative growth rate. While it's not the expectation that utilization levels will revert to historic levels, Mercer believes that these FFS costs will be subject to global inflationary pressures. As a result, the trend rate of 2.4% used for capitated services was applied to FFS wraparound services. Additionally, the Consumer Price Index (CPI) was used as a basis for developing the pharmacy trend assumption of 3.0%. The resulting blended trend rate is 2.5%. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

   ii. **National or regional factors that are predictive of this waiver's future costs.**

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

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

3. **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**

   Utilization adjustments made were service-specific and expressed as percentage factors. The State has

documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

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

Mercer did not estimate cost changes separate from the utilization changes. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

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

Others:

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

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

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

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

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

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

PMPM size of adjustment

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

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

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

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

iii. ☐ Changes brought about by legal action:
Please list the changes.

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

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

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

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

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

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

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

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

C. ☐ Determine adjustment based on currently approved SPA

PMPM size of adjustment

D. ☐ Other

Please describe

v. ☐ Other

Please describe:

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

PMPM size of adjustment

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

Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.

PMPM size of adjustment

D. ☐ Other

Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

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

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

2. ☑ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.

Please describe:

ii. ☐ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost

allocation plan amendment (CAP).

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

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM

size of adjustment

Please describe:

D. ☐ Other

Please describe:

iii. ☑ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.
Historic admin levels decreased from $.38 PMPM 4/09 to 9/09 of the prior waiver to $.14 in the current R2 period. This represents an annualized trend of -25%. While expenses are not expected to increase to levels in the prior waiver, Mercer's expectation is the current admin costs will be subject to inflation. As a result, the service cost trend of 2.2% for P1 and 2.5% for P2 was ultimately 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

10-1-2011 through 3-31-2012

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.
Mercer considers historical year over year trends, as well as rolling averages in making these estimates. As mentioned above, historic reductions in administrative expense levels are not expected to continue.

*The 2.3% stated below in "B" below is on an annualized basis the trend applied to administrative expense for R2 to P2.

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

2.30

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

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

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

Please provide documentation.
Note that while 1915(b)(3) services were provided through R1 and R2, the State will not offer 1915 (b)(3) services as of July, 2012. To accurately develop costs for the projection period, the 1915(b) (3) services were adjusted by -100% to remove the impact. This is accounted for in Column W of Appendix D.5 in the projection of P1 and P2.

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

i.

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

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

B. State Plan Service trend

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

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

1. List the State Plan trend rate by MEG from Section D.I.I.a
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
3. Explain any differences:

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

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b)

cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Basis and Method:

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

Please describe:

1. ☑ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.

Please describe

Section D: Cost-Effectiveness

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K. Appendix D5 – Waiver Cost Projection

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

Spreadsheets sent with email as an attachment to CMS 6-4-12.
Appendix D5 – Waiver Cost Projection

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L. Appendix D6 – RO Targets

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

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

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M. Appendix D7 - Summary

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

Overall, the variance in spending between R1 and P2 is impacted by both the elimination of 1915(b)(3) services and inflationary cost increases. No other programmatic, policy, or pricing changes were applied.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   Enrollment projections are based on historical enrollment trends and expectations for enrollment changes based on recent economic conditions. The changes in enrollment are primarily due to changes in economic conditions and general increases in the population. This forecast does not currently include the Medicaid expansion population effective January 2014 related to the Affordable Care Act. A future amendment will be submitted if necessary.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   Mercer did not estimate cost changes separate from the utilization changes. No adjustments for programmatic, policy, or pricing changes were necessary; therefore, trend estimates do not duplicate the effect of any changes.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   In developing PMPM trends for the time periods from R2 to P1 and from P1 to P2, estimates were based primarily on historical managed care encounter data and quarterly FFS expenses from the CMS 64 reports, with consideration for other data sources such as CPI and DRI. Changes in utilization and unit cost were considered together in developing trend. The trends used are consistent with historical changes in cost and utilization in Washington's Medicaid program with accommodation for the impact of ongoing utilization management.

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

Appendix D7 - Summary