

## Section D – Cost-Effectiveness

**Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section.** Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. In its application and each quarter during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost effective and efficient*. The State must project waiver expenditures for the upcoming waiver period, called Prospective Years (PY) (e.g Prospective Year 1 (P1); Prospective Year 2 (P2); Prospective year 5 (P5) etc.). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective waiver period.

For waivers that include recipients who are eligible for both Medicare and Medicaid benefits (duals) the State may request a waiver period of up to 5 years. Initial waivers and continuation of a waiver beyond its initial approval period requires that the state submit a five-year waiver renewal application and a determination by CMS that, the State's projections demonstrate costs appropriate for the effective and efficient provision of services or for renewals, that while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other Federal requirements, including the submission of mandatory quarterly waiver reports. Each subsequent renewal of the waiver also requires the submission of a renewal application and a CMS determination that the state has continued to meet Federal requirements.

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

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

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

### Definitions and Terminology

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

#### **For Initial Waivers:**

Historical Period:

- BY = Base Year

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

**For Renewal Waivers:**

Retrospective Waiver Period

- RY = Retrospective Year(s)
- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2 when changing from a two year waiver period
- R3 = Retrospective Year 3
- R4 = Retrospective Year 4
- R5 = Retrospective Year 5 Project forward from end of R5 using experience/trends from RY 1 through R5

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

**Part I: State Completion Section**

**A. Assurances**

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

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
  - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:  
\_\_\_\_\_
- c. Telephone Number: \_\_\_\_\_
- d. E-mail: \_\_\_\_\_
- e. The State is choosing to report waiver expenditures based on  
 \_\_\_ date of payment. **(because county mental health plans (MHPs) are also matching agencies incurring certified public expenditures, date of service and date of payment are the same.)**  
 \_\_\_ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

**C. NOT APPLICABLE. Capitated portion of the waiver only: Type of Capitated Contract**

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

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

**The county MHPs under the Medi-Cal specialty mental health services (SMHS) waiver are not paid on a capitated basis. Counties pay with non-federal funds at the time of service. The counties then submit certified public expenditures (CPEs) to the State in order for the State to draw down eligible federal financial participation (FFP) for these services based on the State's adjudication of claims to determine Medi-Cal eligibility. County MHPs receive interim CPE reimbursement of FFP on a fee-for-service (FFS) basis pursuant to approved rates for approved units of service for allowable procedure codes. After the county MHPs are paid FFP on an interim FFS basis, initial cost settlement is completed approximately 24 15—18 months after the close of each state fiscal year (SFY). Final cost reconciliation of county MHP expenses then occurs anywhere from 18 to 36 months after initial cost settlement is completed. Initial cost settlement and final cost reconciliation are also based on county MHP CPEs.**

**D. NOT APPLICABLE PCCM portion of the waiver only: Reimbursement of PCCM Providers**

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

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

- b. \_\_\_ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. \_\_\_ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. \_\_\_ Other reimbursement method/amount. \$ \_\_\_ Please explain the State's rationale for determining this method or amount.

**E. Appendix D1 – Member Months**

Please mark all that apply.

For Initial Waivers only: NOT APPLICABLE

- a. \_\_\_ Population in the BY data
  - 1. \_\_\_ BY data is from the same population as to be included in the waiver.
  - 2. \_\_\_ BY data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. \_\_\_ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. \_\_\_ [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time:  
\_\_\_\_\_
- d. \_\_\_ [Required] Explain any other variance in eligible member months from BY to the final PY \_\_\_\_\_
- e. \_\_\_ [Required] List the year(s) being used by the State as a BY: \_\_\_\_. If multiple years are being used, please explain: \_\_\_\_\_
- f. \_\_\_ [Required] Specify whether the BY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period \_\_\_\_\_.
- g. \_\_\_ [Required] Explain if any BY data is not derived directly from the State's MMIS fee-for-service claims data:  
\_\_\_\_\_

For Renewal Waivers:

- a. X [Required] Population in the BY and the Retrospective years R1, through the end of the waiver period data is the population under the waiver.
- b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete final RY 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 the final RY of the previous waiver period.*
- c. X [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time: **Member months under the waiver equal the full-scope Medi-Cal enrolled population. Actual member months are included in the waiver renewal for all of R1 (which is the four-quarter period July 1, 2011<sup>3</sup> through June 30, 2012<sup>4</sup>) and the first two quarters of R2 (which is the period July 1, 2012<sup>4</sup> – December 31, 2014<sup>2</sup>) as reported to CMS in the quarterly “MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORT” (e.g. Member Months Report) for the SMHS waiver through the December 2012 quarter.**

1. ~~Medi-Cal beneficiaries in Member months for the “Disabled”, “Foster Care”, “MCHIP” and “Other” Medicaid Eligibility Groups (MEGs) for the six twenty-two quarters beginning January 1, 2015<sup>3</sup> through June 30, 2014<sup>20</sup> are estimated and assumed to change based on the average quarterly percentages change in member months from the quarter ending December 31, 2012 through the quarter ending December 31, 2014. Member months for the “Medicaid Expansion” Meg are estimated to change based upon the annual percentage change in the estimated number of Medi-Cal beneficiaries enrolled in Medicaid Expansion aid codes from State Fiscal Year 2014-15 to State Fiscal Year 2015-16 as reported in the January 2015 Governor’s Budget provided by the Department of Health Care Services’ (DHCS) Fiscal Forecasting and Data Management Branch (FFDMB) as included in the January 2013 Governor’s January Budget for SFY’s 2012-13 and 2013-14.~~
- ~~The FFDMB percentage in the Governor’s Budget for SFY 2012/13 is used to estimate the March 2013 and June, 2013 quarterly Member Months (last two quarters of Retrospective Year 02.~~
  - ~~The FFDMB percentage in the Governor’s Budget for SFY 2013/14 is used to estimate the Member Months for P1 (i.e the period July 1, 2013 through June 30, 2014) and P2 (i.e. July 1, 2014 through June 30, 2015).~~

~~Medi-Cal caseload estimates provided by DHCS’ FFDMB are forecast using the most recent 36 months of actual caseload and running multiple regressions for 18 separate beneficiary aid category groupings. This provides the base caseload estimate. To the base caseload estimate are added any estimated caseload impacts of policy changes that are expected to occur during each SFY.~~

2. The California Department of Social Services (CDSS) projected caseload and percentage change included in the January 2013 Governor's Budget for California foster care enrollees is used to estimate the "Foster Care" MEG member months for the: i) two-quarter gap period (e.g. based on the SFY 2012-13 annualized decrease of 7.02 percent contained in the Governor's Budget); and ii) P1 and P2 (based on the SFY 2013-14 estimated annual decrease of 8.02 percent contained in the Governor's Budget). Foster Care and Child Welfare Services caseload forecasts are provided by CDSS' Estimates Branch. Caseloads are reported by funding source, and forecasts are developed by using the most recent actual caseload data trends and running multiple regressions. This provides the base caseload estimate for determining fiscal and case impacts as a result of policy changes.
3. Medi-Cal beneficiaries for the "MCHIP" MEG for the four quarters of calendar year 2013 (i.e. the period January 1, 2013 through December 31, 2013) are assumed to increase by the number of California Children's Health Insurance Program (CHIP) beneficiaries estimated to transition to the Medi-Cal program in these quarters, as also described in the January 2013 Governor's Budget.

In addition, the annual inflation percentage increase for the "MCHIP" MEG contained in the Trend Data table for the two-quarter gap period and the first two quarters of P1 (prior to the CHIP transition) is based on the SFY 2011-12 historical rate of change for monthly MCHIP enrollees. For the last two quarters of P1 and for P2, the caseload weighted average of the rates for MCHIP and the CHIP transition were used, based on the historical SFY 2011-12 rate of change for both MCHIP and CHIP monthly enrollees combined.

4. Amendment #1 projects an additional 575,184 monthly eligibles for the last 6 months of P1 (e.g. January 1, 2014 – June 30, 2014) under the Optional Adult Medicaid Expansion (OAME). This equals an increase of 3,451,104 member months in the new "MEDICAID EXPANSION" Medicaid Eligibility Group (MEG) for P1. Amendment #1 projects an additional 757,405 monthly eligibles, or 9,088,860 member months in the "MEDICAID EXPANSION" MEG for the 12 months of P2. These new beneficiaries are projected to be eligible for Medi-Cal SMHS waiver and Medi-Cal non-SMHS mental health services in accordance with California Senate Bill X1-1, which modified the Medi-Cal program to include Medi-Cal benefits for individuals who meet the eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)).

The quarterly member months reports currently report: i) all Medi-Cal enrolled beneficiaries with eligibility during the quarter and; ii) all Medi-Cal

**enrolled beneficiaries who received “adjusted” eligibility during the quarter for any other months of the waiver term.**

- d. X [Required] Explain any other variance in eligible member months from the BY through the R year(s) to the final Prospective year: **No other changes were applied.**
- e. X [Required] Specify whether the BY/R Y is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **R1 is SFY 2013~~1~~-14~~2~~ (July 1, 2014~~3~~ through June 30, 2012~~4~~) and R2 is SFY 2014~~2~~-15~~3~~ (e.g. July 1, 2014~~2~~ to June 30, 2015~~3~~).** **Actual data, as reported in the “MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORTS” (e.g. Member Months Reports) are displayed in this waiver renewal for R1 and the first two quarters of R2 (July 1, 2014~~2~~ to December 31, 2014~~2~~). Only this actual data, as reported in the Member Months Reports is used in the waiver renewal to calculate the Base Year (BY) PMPM costs. Only member months in the October 2013~~1~~ through December 2012~~4~~ Member Months Reports with dates of Medi-Cal eligibility between July 1, 2014~~3~~ through December 31, 2012~~4~~ (i.e. who had Medi-Cal eligibility within the R07 term) are included as actual member months in Appendix D1 and elsewhere in the Section D Appendices.**

**Medi-Cal eligibility can be established retroactively for beneficiaries based on any of the following factors: i) Social Security Act section 1902 (a) (34); ii) retroactive Medi-Cal eligibility as legally ordered by courts or administrative law judges; and c) retroactive Medi-Cal eligibility based on the determination and approval of federal SSI/SSP eligibility (e.g. Medi-Medi or dual-eligible status) for the beneficiary. For Medi-Cal beneficiaries who obtain retroactive eligibility, retroactive member months are reported in the quarter in which the eligibility first appears in DHCS’ Medi-Cal eligibility system for months included in the current waiver term. Also, as discussed above, only retroactive member months that fall within the current waiver term are included in the Member Months Reports. Thus, any retroactive eligibility for months prior to the current waiver term are not included in the Member Months reports. Member months are reported to CMS quarterly, sixty days after the end of the quarter. For example, for the quarter ended ~~ing~~ March 31<sup>st</sup>, the member months are sent to CMS by June 1<sup>st</sup> of the same calendar year. Once quarterly member months are reported to CMS, they are not changed in subsequent quarters.**

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

For Initial Waivers: NOT APPLICABLE

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

For Renewal Waivers:

- a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: **The same services are included in the Actual Waiver Cost and for the upcoming waiver period. DHCS expects mental health plans will begin to provide Therapeutic Foster Care (TFC) during the upcoming waiver period. An additional program adjustment of 4.4% has been included in D5 to account for additional expenditures related to TFC.**
- b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **All State of California Medi-Cal mental health service costs are included in this waiver. Other non-mental health costs of serving Medi-Cal clients are accounted for in other State of California waivers and/or state plan programs.**

**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 waivers will enter all waiver and FFS administrative costs in the RY or BY.*

For Initial Waivers: NOT APPLICABLE

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

<b>Additional Administration Expense</b>	<b>Savings projected in State Plan Services</b>	<b>Inflation projected</b>	<b>Amount projected to be spent in Prospective Period</b>
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$65,625 or .03 PMPM P2 \$72,166 or .03 PMPM P3 \$79,361 or .03 PMPM P4 \$87,274 or .03 PMPM P5</i>
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

The MHP's allocate their administrative costs among the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of three methods. These allocation methods are to apply: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report.

As indicated in the above paragraph, MHP's have three options regarding allocation of their administrative costs among its various programs. The allocation method for either initial or renewal waivers is explained below including notes regarding the appropriateness of each method to various programs:

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

- a. \_\_\_ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. \_\_\_ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. X Other (Please explain). **For SFY 2011-12 (i.e. R1) the State Department of Mental Health (DMH) directly identified DMH costs associated with administering this Medi-Cal waiver program. Since DMH only operated the Medi-Cal services under this waiver and did not operate/oversee any other Medi-Cal programs, all DMH Medi-Cal costs for R1 are included under this Waiver and there is no need to allocate DMH Medi-Cal costs for R1 between this Waiver and other programs. Additionally, the State Department of Health Care Services (DHCS) incurred some State Medi-Cal administrative costs associated with this waiver for R1. DHCS incurred all state Medi-Cal administrative costs associated with this Waiver in R2, as all DMH Medi-Cal staff responsible for this waiver were transferred to DHCS effective July 1, 2012 (i.e. the beginning of R2). For SFY 2013-14 and SFY 2014-15 DHCS directly identifies DHCS's costs associated with this waiver. DMH and DHCS costs are based on actual percentages of time spent by State staff on this waiver. Finally, county Mental Health Plans (MHP) Administration costs for: i) county administration; ii) quality assurance and utilization review (QA-UR); and iii) Medi-Cal Administrative Activities (MAA), are also included as part of the State Administrative costs. MHPs allocate costs between the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of the three following methods: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report.**

**H. Appendix D3 – Actual Waiver Cost**

a. NOT APPLICABLE The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

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

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$65,625 or .03 PMPM P2 \$72,166 or .03 PMPM P3 \$79,361 or .03 PMPM P4 \$87,274 or .03 PMPM P5
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		<b>(PMPM in Appendix D5 Column W x projected member months should correspond)</b>

For a renewal waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for the RY on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for PY on **Column W in Appendix D5**.

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

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

b. NOT APPLICABLE The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. NOT APPLICABLE Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. \_\_\_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
  2. \_\_\_ The State provides stop/loss protection (please describe):
- d. \_\_\_ NOT APPLICABLE Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:
1. \_\_\_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
    - i. Document the criteria for awarding the incentive payments.
    - ii. Document the method for calculating incentives/bonuses, and
    - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
  2. \_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
    - i. Document the criteria for awarding the incentive payments.
    - ii. Document the method for calculating incentives/bonuses, and
    - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

**Current Initial Waiver Adjustments in the preprint**

**I. NOT APPLICABLE Appendix D4 – Initial Waiver – Adjustments in the Projection for DOS within DOP**

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

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

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

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

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

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

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

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

i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

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

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

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

D. \_\_\_ *Determine adjustment for Medicare Part D dual eligibles.*

E. \_\_\_ Other (please describe):

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

iii. \_\_\_ Changes brought about by legal action (please describe):

For each change, please report the following:

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

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

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

D. \_\_\_ Other (please describe):

iv. \_\_\_ Changes in legislation (please describe):

For each change, please report the following:

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

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

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

D. \_\_\_ Other (please describe):

v. \_\_\_ Other (please describe):

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

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

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

D. \_\_\_ Other (please describe):

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

1. \_\_\_ No adjustment was necessary and no change is anticipated.

2. \_\_\_ An administrative adjustment was made.

i. \_\_\_ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

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

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

C. \_\_\_ Other (please describe):

ii. \_\_\_ FFS cost increases were accounted for.

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

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

C. \_\_\_ Other (please describe):

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

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

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

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

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

2. \_\_\_\_ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.

i. State Plan Service trend

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

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

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

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** \_\_\_\_\_
3. Explain any differences:

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

1. \_\_\_ We assure CMS that GME payments are included from BY data.
2. \_\_\_ We assure CMS that GME payments are included from the BY data using an adjustment. (Please describe adjustment.)
3. \_\_\_ Other (please describe):

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

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

*Method:*

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

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

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

*Basis and Method:*

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

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

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

*Method:*

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

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

*Basis and method:*

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

- j. **Pharmacy Rebate Factor Adjustment :** Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the fee-for-service or capitated base. If the BY 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 BY costs by this percentage. States may want to make separate

adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.

2. \_\_\_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. \_\_\_ Other (please describe):

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

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

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

1. \_\_\_ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. \_\_\_ This adjustment was made:
  - a. \_\_\_ Potential Selection bias was measured in the following manner:
  - b. \_\_\_ The BY costs were adjusted in the following manner:

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

1. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. \_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY data using an adjustment.
3. \_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*

4.\_\_\_\_ Other (please describe):

**Special Note section:**

**Waiver Cost Projection Reporting: Special note for new capitated programs:**

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

- a.\_\_\_\_ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b.\_\_\_\_ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**

**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness**

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

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

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*
1. \_\_\_ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
  2. \_\_\_ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
  3. \_\_\_ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. \_\_\_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  2. \_\_\_ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
      1. \_\_\_ No adjustment was made.
      2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

**J. Appendix D4 -- Renewal Waiver Cost Projection and Adjustments.**

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

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

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The RY 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 RY to the end of the waiver (PY). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State's BY or RY 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 **varies by time period**. Please document how that trend was calculated: **For R1 (i.e. the waiver year July 1, 2013~~1~~ to June 30, 2014~~2~~), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2013~~1~~, December 2013~~1~~, March 2014~~2~~, and June 2014~~2~~ quarterly CMS-64 Reports for waiver year CA17.R07.01 and dividing those expenditures by actual Member Months as reported in the Member Months Reports summed for the same 4 quarters. For the first two (2) quarters of R2 (i.e. the period July 1, 2014~~2~~ to December 31, 2014~~2~~), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2014~~2~~ and December 2014~~2~~ quarterly CMS-64 Reports for waiver years CA17.R07.01 and CA17.R07.02 and dividing these expenditures by the actual member months per MEG as reported in the Member Months Report summed for the same two quarters. The State then included a two quarter gap for the last two quarters of R2 from January 1,**

2013~~5~~ to June 30, 2013~~5~~. The BY PMPM costs per MEG for R2 are then trended for prospective years utilizing DHCS' forecast methodology for each MEG in order to reflect medical service (i.e. cost) inflation under the CA.17 waiver program and to align the PY costs with those included/projected in the SFY 2013-14 Governor's Budget. The DHCS forecast methodology utilizes the federal Centers for Medicare and Medicaid Services (CMS) Home Health Agency Market Basket (HHAMB) Index, prepared by CMS' Office of the Actuary (OACT), computing the annual percentage change in the 4 Quarter Moving Average for each PY.

Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R07~~8~~ was cost effective for R1 in terms of ~~total expenditures~~ State Plan Services aggregate costs and the PMPM per MEG. CA17.R08 waiver Amendment #1 projected total waiver expenditures for Prospective Period 1 (July 1, 2013 – June 30, 2014) to be \$3,710,210,096. Appendix D7 of this waiver renewal shows the actual waiver costs for R1 (July 1, 2013 – June 30, 2014) to be \$1,355,162,869. CA17.R08 waiver amendment #1 projected the prospective period 1 PMPM for each MEG to be the following: Disabled (\$116.84), Foster care (\$468.98), MCHIP (\$11.51), Other (\$16.65), and Medicaid Expansion (\$28.12). Appendix D7 of this waiver renewal shows the actual PMPM for each MEG to be the following: Disabled (\$37.69), Foster Care (\$117.50), MCHIP (\$5.61), Other (\$6.63), and Medicaid Expansion (\$2.34) as well as Total Actual Waiver aggregate costs and PMPM. Despite the fact that R1 was cost effective, the State has determined that the PMPM per MEG for State Plan Services and Total Actual Waiver Costs is significantly underreported for R1. This is because many State Plan service costs for waiver year CA17.R07.01 were not reported in the September 2011, December 2011, March 2012, and June 2012 CMS-64 Reports and thus were not included in Appendix D3 as R1 costs.

Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R07~~8~~ was cost effective for R2 in terms of the projected PMPM for the Disabled, Foster Care, Other, and Medicaid Expansion MEGs. The PMPM for the MCHIP MEG was slightly higher than the projected PMPM for that MEG. The projected PMPM for the cost-effective MEGS were as follows: Disabled (\$120.33), Foster Care (\$482.99), Other (\$17.15), and Medicaid Expansion (\$29.53). Appendix D7 to this waiver shows the PMPM for these MEGs to be as follows: Disabled (\$112.97), Foster Care (\$414.61), Other (\$16.85), and Medicaid Expansion (\$14.56). Amendment #1 to CA17.R08 projected the PMPM for the MCHIP MEG to be \$11.85 in Prospective Year 2 (July 1, 2014 – June 30, 2015). Appendix D7 to this waiver shows the actual PMPM for the MCHIP MEG for the first two quarters to be (\$15.00). California experienced a significant increase in approved claims reported in the quarter ending September 30, 2014 that is contributing to the high PMPM for the MCHIP MEG in R2. State Plan Services aggregate costs for all MEGS and for Total Actual Waiver services costs. R2 was also cost

effective on a PMPM basis for the Disabled, Foster Care and Other MEGs. The R2 State Plan Services PMPM cost slightly exceeded the State Plan Services cost effectiveness projection for the MCHIP MEG. The projected MCHIP PMPM in waiver renewal CA.17.R07 for P2 was \$8.94, but actual PMPM expenditures for this waiver year (i.e. R2) were \$9.19. This exceeds the projected PMPM costs by 2.8 percent. The reason MCHIP PMPM slightly exceeds projections is due to the fact that actual Medi-Cal enrollment in MCHIP was significantly below projections in both R1 (8.7 percent fewer member months than projected) and R2 (6.1 percent fewer member months than projected). However, the number of MCHIP beneficiaries actually served by the CA.17 waiver program in R2 [e.g. those with serious emotional disturbances (SEDs) who actually received services from the county MHPs] and average utilization of services by these beneficiaries did not correspondingly drop. This reflects the fact that despite the lower than projected MCHIP enrollment, those MCHIP eligible individuals with the most serious medical conditions such as SED still enrolled and presented for services, reflecting adverse selection despite lower than projected total enrollment.

The State Plan Services MCHIP PMPM for R2 also clearly reflects a statistical anomaly in that: i) the December 2012 CMS-64 Report contained the largest total dollar volume of CA.17.R07 claims of all six quarters of retrospective data; and ii) the December 2012 CMS-64 Report contained the highest proportion of State Plan Services claims for the retrospective years that were for the MCHIP MEG. To summarize, not only were retrospective year claims highest in the December 2012 quarter (e.g. \$948,752,774), but the percentage of these claims that were MCHIP was also the highest of all six retrospective quarters. MCHIP claims reflected 1.16 percent of all December 2012 State Plan services claims. In contrast, MCHIP claims reflected only: i) 0.77 percent of September 2012 claims; ii) 0.94 percent of June 2012 claims; iii) 1.09 percent of March 2012 claims; iv) 1.00 percent of December 2011 claims; and v) 0.00 percent of September 2011 claims. Even if the December 2012 MCHIP claims had been at the proportion of the next highest retrospective year quarter (e.g. 1.09 percent as reflected in the March 2012 quarter), the MCHIP MEG would have been cost effective for State Plan Services in R2. This data clearly shows that the MCHIP State Plan Services PMPM for R2 exceeded cost projections due to a random statistical anomaly.

Actual MCHIP PMPM has never exceeded the estimated R07.02 projection of \$8.94 in any previous retrospective year since California first began using the current cost effectiveness test in waiver renewal CA.17.R05. The highest previously reported MCHIP actual PMPM in any RY was \$7.28 for waiver year CA.17.R06.02.

Despite the fact that R2 was cost effective, except for the slight variance in the MCHIP MEG, the State believes that the PMPM per MEG for State Plan Services and Total Actual Waiver costs may be somewhat underreported for R2 by between 5 percent to 10 percent. This is because some State Plan service costs incurred for waiver years CA17.R07.01 and CA17.R07.02 which would normally have been reported in the September 2012 and December 2012 CMS-64 Reports may not have been. Specifically:

- A. DHCS' automated accounting system for the waiver CA.17 program through which the State pays the county MHPs FFP and generates the costs included in the CMS-64 Reports was taken off-line for 6 weeks from July 15 – August 31, 2012 for transition from the Department of Mental Health (DMH) to DHCS. This significantly reduced the reporting of CA17.R07.01 costs in the September 2012 quarterly CMS-64 Report below the levels that the State would have normally expected; and
- B. Also as a result of the waiver's transition from DMH to DHCS, county MHPs were required to execute new contracts for waiver services with DHCS beginning October 1, 2012. Many county MHPs were delayed in executing their contracts, with the result that a number of counties could not submit claims for services which the counties paid during the October thru December 2012 quarter. This reduced the reporting of CA.17.R07.02 costs in the December 2012 CMS-64 Report below levels that the State would have normally expected.

Though the December 2012 CMS-64 Report includes "catching up" and paying and reporting to CMS of most of the claims for the July 15 – August 31, 2012 period (during which the State's automated accounting system was off-line) that would have normally been reported in the September 2012 CMS-64 Report the State believes the December 2012 CMS-64 Report did not include a certain proportion of claims for county MHP costs that would have ordinarily been reported for the October through December 2012 period. DHCS believes Factors A and B above resulted in some underreporting of R2 claims on a PMPM basis compared to what the Governor's Budget for SFY 2012/13 (e.g. R2) projects. DHCS will continue to monitor whether any underreporting of R2 claims did occur, and will seek a program/policy/pricing amendment to this Section D for Prospective Years if DHCS determines that Prospective Year costs will likely be higher than those projected in this Section D.

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

- i. X State historical cost increases. Please indicate the years on which the rates are based: BYs The BY PMPM costs per MEG are based on R2 as the BY and are trended for P1, and P2, P3, P4 and P5 utilizing the percentage change in the CMS' HHAMB computing the annual percentage change in the HHAMB 4 Quarter Moving Average for each PY. DHCS' projected increase in costs per member per month does not include other factors. No expenditures or member months for the third or fourth quarters of R2 are included in Appendices D1-D7. Only the first and second quarter R2 actual expenditures and member months are included. The two quarter period January 1, 2013 to June 30, 2013 is a gap period in Section D.

The State Plan service trend percentage increases for P1 is 2.6% and P2 is 2.9%, P3 is 3.1%, P4 is 3.0%, and P5 is 2.9%. based on the HHAMB are: i) 3.9 percent for P1; ii) 2.7 percent for P2. These percentages are reported on Appendix D5 as the State Plan Inflation Adjustment for State Plan Services and administrative costs.

Estimated costs per member per month for each MEG for P1, and P2, P3, P4 and P5 were multiplied by the estimated Medi-Cal beneficiaries for PY to compute estimated expenditures by MEG in Appendix D6 for each prospective year. The percentage change between each prospective year is included for each MEG and reported on Appendix D5 as the State Plan Inflation Adjustment.

Because of the lag in including costs in the CMS-64 Reports for R2 subsequent to the county MHPs paying for services, as described in Section J.a.1., items A. and B., the projections contained in this Section D may be inaccurate once complete costs for each Prospective Year in this waiver renewal are reported to CMS through the CMS-64 Reports.

For the CA.17 waiver, the actual expenditures from the CMS-64 Reports do not predictably account for the normal and expected lag in claims processing. The typical lag in the CA.17 waiver program is that about 95 percent of claims in a given waiver year quarter are reported to CMS from 5 to 8 quarters subsequent to the waiver quarter in which the county MHPs pay for the services. In contrast, 95 percent of member months for each quarter are reported within that waiver quarter. This lack of alignment between the reporting of costs versus the reporting of member months for the CA.17 waiver program results in an uneven PMPM due to expenditures being reported far later, and in an unpredictable fashion, than member months are reported.

- a. NORMAL LAG IN REPORTING COSTS

Since the Medi-Cal Specialty Mental Health Services (SMHS) waiver CA.17 program utilizes MHPs who receive FFP on a post-service fee-for-service (FFS) cost-reimbursement basis utilizing certified public expenditures (CPEs); there is a normal 5—8 quarter lag between the quarter in which the county MHPs actually pay for the services and the quarter in which the State draws down the FFP and reports these service costs in the CMS-64 Reports. Thus, services for which the county MHPs have already paid do not appear in the CMS-64 Reports until a much later time. This pattern reflects the cost-based reimbursement system by which the CA.17 waiver program draws down FFP after county MHPs as providers have paid for services.

Per State law, once a county pays for services, the county has 12 months to submit claims to the State to begin the process of drawing down FFP and reporting the costs in the CMS-64. Once the State receives the claims from the counties, the State takes 30 days to complete adjudication to determine federal Medicaid eligibility, draw down appropriate FFP from California's federal Health Care Deposit Fund, pay the FFP to the county MHPs, and report these costs in the next CMS-64 Report to be transmitted to CMS.

b. UNIQUE LAG FACTORS IMPACTING THE CA.17.R07 WAIVER

As described in Section J.a.1., items A and B, there may have been a unique lag in the reporting of R2 costs which depressed the State Plan PMPM due to:

A. The State's automated accounting system being off-line for 6 weeks from July 15—August 31, 2012 for transition from DMH to DHCS, thus significantly reducing R2 costs reported in the September 2012 CMS-64 Report; and

B. Though much of the "missed" CMS-64 reporting in the September 2012 quarter was included in the December 2012 CMS-64 Report—many county MHPs did not have executed contracts for the period October 1 through December 31, 2012. As a result, these county MHPs were not able to claim for services which they provided and paid for during the December 2012 quarter. Overall, this may have resulted in lower than expected R2 reporting in the December 2012 CMS-64 Report.

Other unique circumstances which continue to have some impact in delaying county MHPs' submitting claims for FFP and the State's reporting of these costs in the CMS-64 Reports include: i) continuing to implement federal Health Insurance Portability and Accountability Act (HIPAA) requirements in the SD2 system with respect to claims payment and privacy of information; ii) the need for county MHPs to implement

their own county-level information technology (IT) – HIPAA-compliant systems which interface with SD2 for claiming purposes; iii) the need for the State and county MHPs to implement dual-eligible/Medi-Medi and additional Other Health Coverage (OHC)/Third Party Liability (TPL) claims processing edits; and iv) a change in State law effective July 1, 2012 allowing county MHPs 12 months from the date of service to submit claims to the State rather than the previous 6 month billing deadline.

In addition, any delayed approval of the State Budget after the June 30<sup>th</sup> deadline of each SFY would force county MHPs to hold back claims since the CA17 waiver program does not have continuous appropriation authority, thus resulting in a lag in CMS-64 Reporting.

Given the “I. NORMAL LAG IN REPORTING COSTS” which are paid to the county MHPs as described above, it is approximately one to two quarters after the quarter in which a county MHP has paid for services, before those county expenditures begin appearing in the CMS-64 Reports. Costs for a given waiver year then rapidly increase over the next two to four quarter period. After this peak period, claims for a given waiver year taper off, with this “normal” lag thus following a bell-shaped curve model of reporting of costs to CMS after the close of each waiver year.

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. As described above, PMPM costs are trended for PYs utilizing the HHAMB. The State’s cost increase calculation does not include any factors other than a price increase.

- ii. \_\_\_\_ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used \_\_\_\_\_. In addition, please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. \_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between RY and P1 and between years P1 and PY.
  - i. Please indicate the years on which the utilization rate was based (if calculated separately only).

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

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

Others:

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

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

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

i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

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

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

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

D. \_\_\_ *Determine adjustment for Medicare Part D dual eligibles.*

E. \_\_\_ Other (please describe):

- ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. \_\_\_ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
- iv. X Changes brought about by legal action (please describe):  
For each change, please report the following:
- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
- B. \_\_\_ The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment \_\_\_\_\_
- C. X Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
- D. \_\_\_ Other (please describe):

**The State is implementing a State Plan Services Programmatic/Policy/Pricing Change Adjustment for P1 and on-going to implement provisions of the KATIE A, etc., et al, v. DIANA BONTA, etc. et al, CLASS ACTION SETTLEMENT AGREEMENT (Case No. CV-02-05662 AHM [SHx]). The State expects county mental health plans to provide therapeutic foster care services during the waiver renewal period and costs associated with these services are not included in the expenditure data reported for R2. The State has estimated the annual cost of this service to be \$15 million. Users of this service will be in the Foster Care MEG. The per member per month increase in the foster care MEG is expected to be \$1.04, which is a .26% increase over the R2 PMPM of \$391.37. The State is included a Programmatic/Policy/Pricing Change Adjustment for P1 of .26%. This December 2011 Katie A. court settlement provides for an increase in existing State Plan Service provision under the CA.17 waiver program for dates of service beginning January 1, 2013. Per the 2013 Governor's Budget for SFY 2013-14, the projected annual increase in CA.17 waiver program existing State Plan services costs for P1 and P2 is projected to be 1.73 percent**

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

The State is implementing a State Plan Services Programmatic/Policy/Pricing Change Adjustment for P1 and on-going to implement provisions of AB 1297, Chesbro (Chapter 651, Statutes of 2011) and pending State Plan Amendment (SPA) #09-004. AB 1297 amended California Welfare and Institutions (W&I) Code section 5720 to allow county MHPs, effective July 1, 2012, to seek reimbursement up to actual cost consistent with federal Medicaid requirements and applicable federal Medicaid upper payment limits (UPLs). Pending SPA #09-004 implements these same provisions.

In R2, approximately \$340,804,213 in medical assistance costs were for dates of service beginning July 1, 2012 and thereafter, reflecting total reimbursement (both FFP and non-federal match) above the SMA and below the lower of actual cost consistent with federal Medicaid requirements or the applicable federal UPL. This is due to the “normal” and “unique” claim lag factors described in sections I.J.a.1 and I.J.a.2. The remaining \$1,028,487,507 for R2 does not reflect the increase of elimination of the SMA. The January 2013 Governor’s Budget projects that an additional \$233,992,000 total funds expenditure will be paid for SFY 2012-13, and \$251,991,000 total funds expenditure will be paid in P1 (i.e. SFY 2013-14) on an accrual basis due to elimination of the SMA. Subtracting out the \$340,804,213 in R2 costs which likely include reimbursement over the SMA, and converting the annual 2013 Governor’s Budget amount to a cash basis (more closely aligned to CMS-64 Reporting), the State projects that the full State Plan Services cost impact of eliminating the SMA will be a 7.89 percent annual increase above the PMPM projected for P1 and future PYs based only on the R2 PMPM and HHAMB. The State is thus projecting a programmatic/policy/pricing increase of 7.89 percent to P1 and P2 to reflect this change.

Amendment #1—Appendix D4 and Appendix D5 (Lines 17 & 35)—establishes a new Medicaid Eligibility Group (MEG) for “MEDICAID EXPANSION” and makes projections for the new 100% FFP OAME population included in this MEG for Medi-Cal SMHS and non-SMHS mental health services provided through the Fee-for-Service Medi-Cal (FFS/MC) program projected to be provided to this 100% FFP OAME non-disabled population age 21 and older. These adjustments are effective January 1, 2014 and impact the last 6 months of P1 and all of P2.

Per Appendix A, Analysis of Mental Health and Substance Use Benefits for the Medi-Cal Coverage Expansion Population included in DHCS’ “Bridge to Reform Waiver, Mental Health and Substance Use Disorders Services Plan (Services Plan)” which

was submitted to CMS on September 30, 2013, it is projected that 575,184 average monthly eligibles (3,451,104 member months) and \$97,045,016 in total Medi-Cal SMHS and non-SMHS mental health service costs will be incurred for the last 6 months of P1 for these beneficiaries. For P2, 757,405 average monthly eligibles (9,088,860 member months) and \$268,357,772 in total costs are included in Appendix A for these beneficiaries.

For the above service costs, the “Services Plan” states that 13% of the funding for Medi-Cal SMHS is projected for county administration. As a result, of the \$18.88 Per Member Per Month (PMPM) (\$65,156,824/3,451,103 member months = \$18.88) projected in Appendix A for Medi-Cal SMHS in P1, 13% or \$2.4544 PMPM is for Administrative costs. (\$2.4544 PMPM times 3,451,103 member months = \$8,470,387 P1 administrative costs). Of the \$19.82 PMPM (\$180,177,622/9,088,860 member months = \$19.82) projected for Medi-Cal SMHS in P2, 13% or \$2.5766 PMPM is projected for Administrative costs. (\$2.5766 PMPM times 9,088,860 member months = \$23,418,357). All of the funding contained in Appendix A for Medi-Cal mental health pharmacy is for State Plan services and not administration.

As a result, Appendix A and the “Services Plan” projects \$88,574,629 (i.e. \$97,045,016 minus \$8,470,387 = \$88,574,629) for State Plan Services costs for the second half of P1 and \$244,939,415 (i.e. \$268,357,772 minus \$23,418,357 = \$244,939,415) for State Plan Services costs for P2 for OAME beneficiaries.

The Trend Data and Appendix D1 include the member months for P1 and P2 projected in Appendix A from the “Services Plan”. Appendix D5, Line 17, Column O, includes the projected increase in PMPM State Plan Services costs for the new “MEDICAID EXPANSION” MEG needed to include the 100% FFP OAME utilization PMPM.

- vi. \_\_\_ Other (please describe):
- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):

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

1. \_\_\_ No adjustment was necessary and no change is anticipated.
2. X An administrative adjustment was made.
  - i. \_\_\_ Administrative functions will change in the period between the beginning of P1 and the end of PY. 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: \_\_\_\_\_. Please document how that trend was calculated:
    - D. \_\_\_ Other (please describe):
  - iii. X [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
    - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: BYs **Actual State administrative costs were trended forward at the State Plan services trend rate, which utilized the percentage change in the HHAMB index, are state FYs 2006-07, 2007-08 and 2008-09.** 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.

**CA17 administration inflation rates for P1, and P2, P3, P4 and P5 are based on the percentage change in the HHAMB 4 quarter**

moving average for each PY, which is the state plan services trend rate. These rates are reported on Appendix 5 as the Administration Inflation Adjustment, a 3 year weighted average trend of administrative costs calculated for SFYs 2006-07 through 2008-09. This inflation rate cost increase calculation does not include any factors other than a price increase.

PMPM costs for Administration for R1 and the first two quarters of R2 were calculated by apportioning total administration costs for each of waiver years R1 and R2 to each MEG based on the ratio of each MEGs State Plan Service costs for the waiver year to the total State Plan Service costs for that same waiver year as contained in Appendix D3. This calculated ratio of each MEGs Administration costs are then divided by the actual Member Months per MEG as reported in Appendix D1 for the same waiver year to obtain the Administration PMPM for each RY.

Estimated costs per member per month for each MEG for Administration for P1, and P2, P3, P4 and P5 are then multiplied by the estimated Medi-Cal beneficiaries projected for each PY to compute estimated administration expenditures by MEG for each prospective year in Appendix D6. The percentage change between each prospective year is then computed for each MEG and reported on Appendix D5 as the Administration Inflation Adjustment.

#### NORMAL LAG IN REPORTING ADMINISTRATION COSTS

- The same "normal" lag as described for reporting State plan services costs in the CMS-64 Reports in sections I.J.a.1 and I.J.a.2 applies to the reporting of CA17 Administration costs for R1 and R2. As a result, actual Administration costs reported for R1 and R2 of the CA17.R07 waiver renewal do not properly reflect expected Administration cost claiming.

UNIQUE LAG IMPACTING THE CA.17.R07 WAIVER—There is also a "unique lag" in the reporting of actual Administration costs for R1 and R2 in Appendices D2A and D3. On September 28, 2011 the State issued guidance to county MHPs via All County Letter (ACL) #11-01 changing the manner in which counties were to bill the State for: i) county administration; ii) quality assurance and utilization review (QA-UR); and iii) specialty mental health Medi-Cal Administrative Activities (MAA) costs. There was a delay to make necessary changes to the State accounting reimbursement system in order to process, pay and report these Administration costs in the quarterly CMS-64 Reports. The State needed to re-program their accounting

reimbursement system to handle the revised county administrative claim form beginning in December 2011. However, the transition of staff from the specialty mental health services program and the State's accounting reimbursement system to DHCS from September 2011 through July 2012 delayed the State from implementing these changes. DHCS staff instead focused on making the necessary changes to the accounting reimbursement system in order to continue payment of county MHP medical assistance costs through the calendar year 2012 transition period. The State had to delay completion of the system changes needed in order to reimburse counties (and report in the CMS-64 Reports) payments for Administration. As a result, very little of the CA.17.R07.01 and CA.17.R07.02 Administration costs incurred by county MHPs have yet been reported in the CMS-64s. The change in county billing requirements and delay in implementing State system changes resulted in very low levels of county Administration being reported for R1 and R2. DHCS completed implementation of the USL Financial system changes to pay Administration costs in January 2013. The vast majority of CA.17.R07.01 and CA.17.R07.02 Administration costs will be reported in the upcoming March 2013 and June 2013 CMS-64 Reports. In upcoming CMS-64 Reports, DHCS anticipates annual payment of Administration costs to be approximately \$280 million dollars for each of waiver years CA.17.R07.01, CA.17.R07.02 and approximately \$359.7 million in P1.

The State is thus adding a lag factor in Appendix D5, Column Y, to project Administration costs from R2 to P1 to accurately reflect the Administration costs contained in the most current January 2013 Governor's Budget for county administration for P1. With the accounting reimbursement system changes for Administration costs now completed, DHCS projects reporting of Administration costs in the CMS-64 Reports to return to an approximate \$359.7 million per year in P1 plus the applicable Administration cost inflation factor included in Appendix D5 for P2.

The percentage change between each of prospective years P1 and P2 is computed for each MEG and reported on Appendix D5 as the Administration Inflation Adjustment utilizing the 3 year weighted average trend of administrative costs described above.

Amendment #1—Appendix D4 and Appendix D5 (Lines 17, Column AD)—includes a projected Administrative cost adjustment for the new "MEDICAID EXPANSION" MEG for

**100% FFP OAME beneficiaries who will receive Medi-Cal SMHS. This adjustment is effective January 1, 2014 and impacts the last 6 months of P1 and all of P2.**

**The “Services Plan” states that 13% of the funding for Medi-Cal SMHS contained in Appendix A of the Service Plan is projected for county administrative costs. As a result, of the \$65,156,824 projected in Appendix A for Medi-Cal SMHS in P1, \$8,470,387.20 (e.g. 13%) is for Administrative costs and of the \$180,177,622 projected for Medi-Cal SMHS in P2, \$23,418,356.68 (e.g. 13%) is projected for Administrative costs.**

**Appendix D5, Line 17. Column AD, includes this projected increase in Per Member Per Month (PMPM) in the new “MEDICAID EXPANSION” MEG for Administrative costs needed to include the new 100% FFP OAME utilization PMPM.**

**The lack of alignment between the reporting of Administration costs versus the reporting of member months for the CA.17 waiver program results in an uneven and unpredictable Administration PMPM due to expenditures being reported far later than member months are reported.**

- B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.
- d. **1915(b)(3) Trend Adjustment: NOT APPLICABLE** The State must document the amount of 1915(b)(3) services in the RY/BY **Section D.I.H.a** above. The RY/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the RY/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (PY). Trend adjustments may be service-specific and expressed as percentage factors.
- 1.\_\_\_\_ [Required, if the State’s BY or last RY is more than 3 months prior to the beginning of P1 to trend BY or RY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
  - 2.\_\_\_\_ [Required, when the State’s BY or last RY is trended to the last PY. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State’s trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
    - i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based:  
BYs \_\_\_\_\_
  2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
- ii. State Plan Service Trend
1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above \_\_\_\_\_.
- e. **Incentives (not in capitated payment) Trend Adjustment:** NOT APPLICABLE Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.J.a** \_\_\_\_\_
  2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** \_\_\_\_\_
  3. Explain any differences:
- f. **Other Adjustments** including but not limited to federal government changes. (Please describe): NOT APPLICABLE
- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust PY 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:** Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the capitated base. If the BY 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 BY costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.

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

3. \_\_\_ Other (please describe):

1. \_\_\_ No adjustment was made.

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

#### **K. Appendix D5 – Waiver Cost Projection**

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

#### **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.

**The State utilizes a cost effectiveness monitoring process whereby any variances in PMPM cost by MEG are identified, researched and discussed so that the State can discuss such findings with CMS and prepare any necessary waiver amendments.**

**The State monitors retrospective year costs based on all actual costs for each waiver year reported in the CMS-64 Reports during that waiver year. The State updates and reviews cumulative costs for each RY at the time each final quarterly CMS-64 Report during that waiver year is transmitted by the State to CMS. The State compares both the aggregate and PMPM costs per MEG for State Plan Services and Administration for each retrospective waiver year to the Appendix D6, RO Targets. If the PMPM per MEG for any waiver year within a particular waiver term exceeds the Appendix D6 targets, the State determines what factors caused the PMPM to exceed the waiver year projection – including State Plan Trend and Administration Cost factors such as: i) changes in the CMS-64 Reporting lag and those factors causing the change; ii) reporting of costs by county; iii) reporting of costs by service type; iv) the number of beneficiaries that received services per waiver quarter/year compared to member months for the same waiver quarter/year (e.g., “caseload” or penetration rate); v) the number of services per beneficiary (e.g. utilization); vi) rate changes; vii) administrative/statutory/legal changes; and/or viii) other changes that may impact quarterly or annual PMPM costs.**

**The unpredictable lag in reporting payments made by the county MHPs in the CMS-64 Reports due to both the “normal” lag and any “unique” lag factors makes it difficult to align actual waiver year expenditure data with actual member months for the same waiver years. Collating, reviewing and trending State plan service and Administration costs over more retrospective years may better identify actual costs for each waiver year. Without reviewing waiver costs over a greater number of retrospective years, the projections contained in this Section D for waiver renewal CA.17.R08 may be inaccurate until complete costs for each RY are reported to CMS in future CMS-64 Reports.**

The State may request additional amendments to this Section D in the future to properly align actual costs and member months for each waiver year and address any other programmatic/policy/pricing changes to either the State Plan Trend or Administration Costs that occur during this waiver term.

M. **Appendix D7 - Summary**

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

As described in Part I Section J.a.1. and I.Ja.2, and included in Appendix D5, Column J, the State has included the HHAMB inflation factor for State Plan services in each PY.

As described in Part I Section J.c.2.iii., and included in Appendix D5, Column Y, rows 13 through 16—the State has included a “unique” lag factor increase from R2 to P1 in Appendix D4 and Appendix D5 for Administration costs. This adjustment accounts for the lack of reporting of R1 and R2 Administration costs due to the factors described in Section J.c.2.iii.A. This adjustment aligns R2 to P1 Administration costs with those Administration costs included/projected in the January 2013 Governor’s Budget for SFY 2013/14 (e.g. P1) for R2 to P1.

As described in Part I Section J.c.2.iii., and included in Appendix D5, Column Y for P2—the State has included an Administration inflation adjustment.

As described in Part I Section J.b.2.iv. and reflected in Appendix D5, Column L, rows 13 through 16, the State has included a Programmatic/Policy/Pricing Change Adjustment for the Katie A. court settlement.

As also described in Part I Section J.b.2.iv. and also reflected in Appendix D5, Column L, rows 13 through 16, the State has included a Programmatic/Policy/Pricing Change Adjustment for AB 1297 which allows billing of State Plan Services above the former SMA up to the lower of actual cost consistent with federal Medicaid requirements or the applicable federal UPL.

As described in Part I., Section J.b.2.v. D and in Appendix D5, Line 17, Column O, the State has included in Amendment #1 a State Plan Programmatic/policy/pricing adjustment for the new “MEDICAID EXPANSION” MEG for the newly eligible 100% FFP OAME population: i) served under the Medi-Cal SMHS waiver; and ii) for increased non-SMHS mental health services provided to the new 100% FFP OAME adult non-disabled beneficiaries through the FFS/MC program including Medi-Cal mental health pharmacy services (i.e. anti-psychotic drugs).

As described in Part 1., Section J.c.2.iii.A., and in Appendix D5, Line 17, Column AD, the State has also included in Amendment #1 an Administrative Cost Adjustment for the new “MEDICAID EXPANSION” MEG for the newly eligible 100% FFP OAME population served under the Medi-Cal SMHS waiver.

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**:

As described in Part I., Section E.c for Renewal Waivers, member months are projected to change based upon the average quarterly rate of change experienced from the quarter ending March 31, 2013 through the quarter ending December 31, 2014. This trend in member months is not expected to impact the annualized rate of change in Appendix D7, Column I. Medi-Cal beneficiaries for the MCHIP MEG for the four quarters of calendar year 2013 (e.g. the period January 1, 2013 through December 31, 2013) are assumed to increase by the number of California Children’s Health Insurance Program (CHIP) beneficiaries estimated to transition to Medi-Cal in each of these quarters described in the January 2013 Governor’s Budget. This CHIP transition to MCHIP is estimated to occur in the last two quarters of R2 (e.g. the lag period) and first two quarters of P1. The estimated increase in MCHIP beneficiaries due to this CHIP transition are included in Appendix D1.

As described in Part I., Section E.c. for Renewal Waivers, Medi-Cal beneficiaries are estimated and assumed to change based on the percentage factors described for each MEG in Section E.c.

As described in Part 1., Section E.c.4., Amendment #1 projects an increase of 575,184 monthly eligibles for the last 6 months (January 1, 2014 – June 30, 2014), or 3,451,104 member months, for the new OAME population in the new “MEDICAID EXPANSION” MEG for P1 and 757,405 monthly eligibles, or 9,088,860 member months, for the 100% FFP OAME population in the “MEDICAID EXPANSION” MEG for P2.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State’s explanation of cost increase given in **Section D.I.I and D.I.J**: Unit cost changes are anticipated to increase by the percentage change in the HHAMB 4 quarter moving average for each PY. This factor impacts the annualized rate of change in Appendix D7 Column I. The change due to this unit cost increase for P1 is 2.6%, for P2 is 2.9%, for P3, is 3.1%, for P4 is 3.0%, and for P5 is 2.9%. from R2 to P1 as described in Part I. Section J.b.2.v. and reflected in Appendix D5, Column L,

rows 13 through 16, as a result of implementation of AB 1297 and pending SPA #09-004.

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: The State is expecting utilization of therapeutic behavioral services to increase during the period of the waiver renewal. The cost of this increased utilization in the Foster Care MEG is factored into P1. This increase in utilization impacted the annualized rate of change for the Foster Care MEG by .3. Utilization changes are anticipated to increase from R2 to P1 as described in Part I, Section J.b.2.iv. and reflected in Appendix D5, Column L, rows 13 through 16, as a result of implementation of the Katie A court settlement.**

Utilization for the new OAME population in the new "MEDICAID EXPANSION" MEG included in Amendment #1 for dates of service beginning January 1, 2014 is anticipated to reflect "adverse selection" with those OAME individuals most in need of health care services enrolling earlier. Appendix A of the "Bridge to Reform Waiver, Mental Health and Substance Use Disorder Services Plan" reflects a total \$28.12 PMPM for the last 6 months of P1 and \$29.53 PMPM for P2 for 100% FFP OAME. Of this amount, \$2.45 PMPM and \$2.58 PMPM reflects SMHS Administrative costs for the last half of P1 and P2 respectively. Amendment #1, Appendix D5, Lines 17 and 35, include these PMPMs for the new 100% FFP OAME population included in the "MEDICAID EXPANSION" MEG.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**. No other principle factors other than those described above contributed to the overall annualized rate of change in the cost per member per month.

## **Part II: Appendices D.1-7**

Please see attached Excel spreadsheets.