Section 1915(b) Waiver
Proposal for California Advancing and Innovating Medi-Cal (CalAIM)

Updated December 16, 2021
with technical corrections incorporated January 2022

Amendment Submitted November 4, 2022
Updated June 23, 2023

Cost Effectiveness Amendment Submitted October 10, 2024

Submitted to the Centers for Medicare & Medicaid Services on June 30, 2021 and amended on November 4, 2022, for Waiver Period of January 1, 2022, to December 31, 2026

MMA Amendment Version of 1915(b) Waiver Preprint (July 18, 2005)

Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

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

The **name of the waiver program** is ***California Advancing & Innovating Medi-Cal (CalAIM)***. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:
___ initial request for new waiver. All sections are filled.

_**X** __ amendment request for existing waiver, which modifies the following Section(s)/Part(s): Section A (Tribal Consultation pages only); Section D

_**X** _ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver). Document is replaced in full, with changes highlighted

__ renewal request

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

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

Section A is __ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is __ replaced in full

___ carried over from previous waiver period. The State:

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

Effective Dates: This amendment is effective ***January 1, 2025*** and ending ***December 31, 2026***. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is ***Saralyn Ang-Olson*** and can be reached by telephone at ***(916) 345-8380***, or fax at ***Not Applicable***, or e-mail at ***Saralyn.Ang-Olson@dhcs.ca.gov***. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

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

DHCS Response

The State regularly seeks advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs (IHPs), or Urban Indian Organizations as required by the American Recovery and Reinvestment Act of 2009 (ARRA). On April 7, 2021, California's Department of Health Care Services (DHCS) provided a memorandum to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see Tribal public notice). The State requested that comments be provided within 30 days of the date of the memo, or May 7, 2021.

On April 7, 2021, the State shared the Tribal public notice and information for the Tribal and designees of IHPs advisory meeting to be held on April 30, 2021, via email to the IHPs' listservs. The public notice and information were also posted on the DHCS IHP homepage and in the Notices of Proposed Changes to Medi-Cal Program webpage.

On April 30, 2021, from 2:00 to 3:30 pm Pacific Time, State Medicaid Director Jacey Cooper, along with the DHCS Primary, Rural, and Indian Health Division (PRIHD), hosted the Tribal advisory meeting with approximately 43 attendees. The meeting was held electronically via Zoom to promote social distancing and mitigate the spread of COVID-19. The State made online video streaming and telephonic conference capabilities available to ensure statewide accessibility, as well as closed captioning. During the webinar, Director Cooper provided an overview of the CalAIM waivers, highlighted the potential impact on Tribes of the changes to the Medi-Cal program proposed in the CalAIM waivers, and engaged in a discussion with participants to consider questions and comments.

During the meeting, participants raised concerns about the conclusion of the Tribal Uncompensated Care (UCC) program under the CalAIM Section 1115 demonstration application and impacts to Tribal health programs that do not elect to become Tribal Federally Qualified Health Centers (FQHCs). Additionally, commenters were concerned that Tribal FQHC policies were not yet published. Participants also noted support for the proposed Indian Health Program Organized Delivery System (IHP-ODS), including access to traditional healers and natural helpers in the Drug Medi-Cal-Organized Delivery System (DMC-ODS) program as a way to provide culturally appropriate substance use disorder (SUD) services and supports. The State thanked the Tribes for the operational questions and support and responded that additional details on the

Tribal FQHCs' implementation would be available later in May 2021. DHCS published additional Tribal FQHC guidance on May 14, 2021, including details for providers on billing services rendered by Tribal FQHCs and billing codes, and reviewed the new policy with IHP providers and Tribal organizations on June 11, 2021. As described above, in response to comments, DHCS is seeking authority under the CalAIM Section 1115 demonstration to reinstate the Tribal UCC payments for chiropractic services, which are not accessible for Tribal health programs that do not elect to enroll as a Tribal FQHC.

The PowerPoint presentation used during the Tribal public hearing was posted on the DHCS IHP's Meetings, Webinars, and Presentations webpage and is accessible here.

In addition to the April 30 webinar, DHCS also discussed the CalAIM Section 1115 demonstration application during the regularly scheduled Tribal Quarterly Meetings (March 5, 2021, & May 28, 2021). During the May 28 webinar, DHCS received three comments regarding payment rates for Peer Support Specialists, natural helpers, and traditional healers, as well as a request to continue the Tribal UCC program and a request for responses to public comments submitted during the CalAIM Waiver public comment period on the waiver proposals. DHCS thanked the Tribes for their questions and noted all public comments will be posted on the DHCS CalAIM 1115 Demonstration & 1915(b) Waiver webpage, with responses addressed in the CalAIM Section 1115 demonstration application.

DHCS Update for November 2022 Amendment

For the coordinated CalAIM Section 1915(b) and Section 1115 amendments submitted to CMS in November 2022, the State shared the Tribal public notice on August 12, 2022 via email to the IHPs' listservs and held a webinar for Tribal and designees of IHPs advisory meeting on August 31, 2022. The public notice and information were also posted on the DHCS IHP homepage and in the Notices of Proposed Changes to Medi-Cal Program webpage.

DHCS Update for October 2024 Cost Effectiveness Amendment

In the amendment submitted to CMS in October 2024, the State is seeking technical changes to cost effectiveness to reflect policy updates implemented by California through other authorities. Specifically, the cost effectiveness updates reflect:

- *Changes related to California's Managed Care Organization (MCO) tax and directed payments, among others, which do not directly impact tribal populations;*
- *Changes to the State Plan to reflect new behavioral health benefits related to the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative, which underwent tribal consultation during the BH-CONNECT State Plan Amendment process.* These benefits include Enhanced Community Health Worker Services and the following Evidence-Based Practices: Assertive Community Treatment, Forensic Assertive Community Treatment, Coordinated Specialty Care, Supported Employment, and Clubhouse.

Section D – Cost-Effectiveness

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

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

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

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

Part I: State Completion Section

A. Assurances

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

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

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: **- *Rafael Davtian***

c. Telephone Number: ***(916) 322-5603***

d. E-mail: ***rafael.davtian@dhcs.ca.gov***

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

X date of payment *(Applies to SMHS, DMC-ODS)*.

X 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. *(Applies to MCMC, Dental MC)*

DHCS Response

DHCS is reporting base and projected waiver expenditures on a date of payment basis for SMHS and DMC-ODS and a date of service basis for MCMC and Dental MC. The date of payment basis is consistent with existing and previous reporting for SMHS and DMC-ODS due to the cost-based financing and payment methodology for behavioral health services. Under CalAIM, DHCS aims for further delivery system integration and administrative simplification. When DHCS moves to a rate-based financing and payment methodology for behavioral health services, DHCS will be able to align waiver expenditure reporting for MCMC, Dental MC, SMHS, and DMC-ODS on a date of service basis.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—

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

a.__ The State provides additional services under 1915(b)(3) authority.

b. **X** The State makes enhanced payments to contractors or providers. *(Applies to MCMC, Dental MC)*

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

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

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

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

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

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

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

a. **X** MCO *(Applies to MCMC)*

b. **X** PIHP *(Applies to SMHS, DMC-ODS)*

c. **X** PAHP *(Applies to Dental MC)*

d. ___ Other (please explain):

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

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

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 base year data
1.___ Base year data is from the same population as to be included in the waiver.
2.___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
_____

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

e.____[Required] List the year(s) being used by the State as a base year:____.

If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____[Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

_____

For Conversion or Renewal Waivers:

a. **X** [Required] Population in the base year and R1 and R2 data is the population under the waiver. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

b. **X** For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period. (Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

DHCS adjusted the formulas to calculate the annualized trend rates correctly.

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

DHCS Response

MCMC and Dental MC: *The base year member months include all Medi-Cal managed care populations under the waiver enrolled in State Fiscal Year (SFY) 2018-19. Although total member months in P1 are anticipated to be higher due to the moratorium on eligibility redeterminations during the public health emergency, with subsequent decreases anticipated in P2 and P3 due to the resumption of eligibility determinations, at this time DHCS is not projecting an increase or decrease in member months over the term of the waiver for purposes of the cost-effectiveness calculation, with one exception in P2 (described further below). Due to the high number of programmatic/policy/pricing change adjustments applicable to MCMC and Dental MC, DHCS believes that holding member months constant facilitates the identification and review of the impact of changes applicable during each year of this waiver. DHCS will continue to monitor caseload and may, in the future, work with CMS to amend the cost-effectiveness calculation to reflect an updated projection – especially if any changes to caseload are anticipated to materially change the per-capita expenditure level projected for an eligibility grouping.*

A caseload increase is assumed in P2 for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., County Organized Health System (COHS) and Coordinated Care Initiative (CCI) counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).

DHCS is requesting an amendment to revise projected member months for P4 and P5 based on recent data pertaining to the COVID-19 Public Health Emergency (PHE) unwinding and other changes since the base year. Amended member month projections for P4 and P5 are set equal to actual member months submitted to CMS in P2. While enrollment continues to be uncertain, DHCS believes that the amendment improves upon the previously submitted projections.
***SMHS and DMC-ODS:** DHCS is projecting an increase in member months in P1 due to the moratorium on eligibility redeterminations during the public health emergency. It is likely to take a year to bring current all redeterminations. Member months decrease in P2 and P3 due to the resumption of eligibility determinations and is consistent with California's decline in Medi-Cal enrollment prior to the COVID-19 Public Health Emergency (PHE). The base year member months data includes all Medi-Cal beneficiaries enrolled in State Fiscal Year 2018-19, which includes quarter ending September 30, 2018 through quarter ending June 30, 2019.*

On May 1, 2022, DHCS began enrolling non-citizens with unsatisfactory immigration status who are over 49 years of age in its State Only Medi-Cal program. By January 2024, DHCS will begin enrolling non-citizens with unsatisfactory immigration status between the ages of 26 and 49 in its State Only Medi-Cal program. Non-citizens with unsatisfactory immigration status are eligible to receive pregnancy related and emergency services through the federal Medicaid program. DHCS is projecting a 1.4% increase in member months as a result of enrolling those who are over 49 years of age and an increase of 5.48% as a result of enrolling those who are between 26 and 49. DHCS has updated the projected member months in Projected Years 1 through 5 to reflect these changes.

*To account for non-citizens with unsatisfactory immigration status over 49 years of age, DHCS increased the member months reported in quarter 2 by .93% (1.4%*2/3) and increased the member months in all subsequent quarters by 1.4%. To account for non-citizens with unsatisfactory immigration status between 26 and 49 years of age, DHCS increased the member months reported in quarters 9 through 20 by 5.38%.*

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

DHCS Response

MCMC and Dental MC: *In P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.*

SMHS and DMC-ODS: *No other changes*.

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

DHCS Response

MCMC, Dental MC, SMHS, and DMC-ODS: *BY/R1/R2 are SFY. BY reflects SFY 2018-19 (June 1, 2018 through September 30, 2019)*.

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 Conversion or Renewal Waivers:

a. **X** [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

DHCS Response

The previous 1915(b) waiver only included mental health services. This renewal waiver includes:

- *most components of the physical health and dental managed care delivery systems, which transitioned from the 1115 demonstration authority to the 1915(b) waiver; and*
- *substance use disorder services provided through DMC-ODS counties, which also transitioned from 1115 demonstration authority to the 1915(b) waiver.*

MCMC and Dental MC: *The Actual Waiver Cost in Appendix D3 represents expenditures under the 1115 demonstration that, with a few exceptions, align with services and populations under this renewal waiver. To address these exceptions, notably the carve-out or carve-in of certain services in P1 or P2, DHCS applied program adjustments to the P1 and P2 projected expenditures as described in Section D.I.J.b.2.vi.D below.*[1]

SMHS and DMC-ODS: *The State Plan costs reported in Appendix D5 for the base year includes expenditures for mental health services assigned to the 1915(b) waiver and expenditures for substance use disorder services assigned to the DMC-ODS 1115 demonstration reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019. DHCS also included a program adjustment in Prospective Year 2 to account for 10 new counties starting to provide substance use disorder services through the 1915(b) PIHP delivery system. DHCS included costs for lab or radiology in the retrospective state plan cost for SMHS. DHCS also included costs for the following specialty mental health impacted services: Psychiatric inpatient hospital services, other practitioners, physicians, pharmacy, long term care, and mental health services provided in FQHCs.*

Service categories that have checkmarks in both Columns H and I reflect certain services in this category are responsibility of the psychiatric inpatient hospital services (either in the SMHS or DMC-ODS delivery system) as well as certain services in this category that are impacted by the psychiatric inpatient hospital services (either in the SMHS or DMC-ODS delivery system)

[1] Effective January 1, 2022, pharmacy and related benefits (listed in Attachment III) that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, medical supplies and enteral nutritional products, as described in the Medi-Cal Rx All Plan Letter (APL 20-020) will be carved out of Medi-Cal managed care capitated benefits. Pharmacy and related benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs, medical supplies and enteral nutritional products, that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020), will remain carved in to Medi-Cal managed care capitated benefits.

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:

DHCS Response

MCMC and Dental MC: *DHCS has excluded from the cost-effectiveness analysis the following: 1) services delivered through the Medi-Cal managed care delivery system but not included in this waiver, such as Community-Based Adult Services (included in 1115 demonstration authority) and services for Out-of-State Former Foster Care Youth; 2) services carved out of the Medi-Cal managed care delivery system, such as In-Home Supportive Services and 1915(c) waiver HCBS services; 3) expenditures for Programs of All-Inclusive Care for the Elderly; and 4) state-only services provided through the Medi-Cal managed care delivery system for which DHCS does not seek federal authority or claim federal funds.*

SMHS and DMC-ODS: *All Medi-Cal mental health service costs and substance use disorder service costs, except for the following costs, are accounted for in this waiver: 1) the cost of substance use disorder services provided by prepaid inpatient health plans (PIHP) in an Institution for Mental Disease (IMD), and 2) the cost of specialty mental health and substance use disorder services provided by PIHPs to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims. The cost of state plan substance use disorder services provided to beneficiaries residing in counties that do not provide substance use disorder services through a PIHP delivery system are excluded from this waiver. DHCS included a program adjustment in Prospective Year 2 to account for the cost of 10 new counties to begin providing substance use disorder services through a PIHP delivery system. The cost of substance use disorder services provided to beneficiaries in an IMD and the cost of substance use disorder services provided to AI/AN beneficiaries is separately accounted for in the State's 1115 demonstration and it is not included in the State's 1915(b) renewal waiver. California included a program adjustment in Prospective Year 1 to remove the cost of specialty mental health and substance use disorder services provided to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims.*

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

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

For Initial Waivers: *[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.

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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).

DHCS Response

MCMC and Dental MC: *DHCS is directly identifying administrative costs associated with this waiver. Reported amounts are based on actual or estimated program administration costs for State staff, related overhead/support costs, and administrative contractors (e.g., actuarial, Information Technology) dedicated to the Medi-Cal managed care delivery system. The EQRO costs included in the MCMC and Dental MC cost*

effectiveness calculations are specific to these delivery systems and do not overlap with the SMHS and DMC-ODS delivery systems.

SMHS and DMC-ODS: *DHCS directly identifies DHCS' costs associated with this waiver. DHCS costs are based on actual percentages of time spent by State staff on this waiver. County-operated PIHPs Administration costs for: i) PIHP 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. The EQRO costs included in the SMHS and DMC-ODS cost effectiveness calculations are specific to these delivery systems and do not overlap with the MCMC and Dental MC delivery systems.*

H. Appendix D3 – Actual Waiver Cost

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

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

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections
[NOT APPLICABLE]

1915(b)(3) Service	Savings ~~projected~~ accrued in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Total	***(PMPM in Appendix D5 Column T x projected member***		**(PMPM in Appendix D5 Column W x projected member**

	months should correspond)		**months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections *[NOT APPLICABLE]*

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b. X The State is including voluntary populations in the waiver *(Applies to MCMC, Dental MC)*.

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

DHCS Response

MCMC and Dental MC: *Voluntary populations in the waiver were voluntary prior to the waiver including the base year. DHCS has no knowledge of or reason to anticipate material changes in selection between the base year and years under the waiver. Examples of voluntary populations include: 1) beneficiaries in San Benito County choose between a single commercial plan and FFS, and enrollment in managed care is voluntary in P1 and P2, after which San Benito converted to a COHS county with corresponding mandatory enrollment in managed care; 2) Foster Youth in non-COHS counties; and 3) dually eligible beneficiaries except in COHS and CCI counties in P1 only (January 1, 2022 through December 31, 2022), after which they will be mandatorily enrolled in managed care statewide.*

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

Basis and Method:

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

2.___ The State provides stop/loss protection (please describe):

DHCS Response

This question appears out-dated. Per 42 CFR § 438.6(b), the State is not required to provide or require reinsurance or stop-loss.

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

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

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

2._____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.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. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP *[NOT APPLICABLE]*

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments):

States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

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

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

   1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

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

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

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

   3.____The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment

reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

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

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

Others:

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

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

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

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

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

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

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

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

E.____ Other (please describe):

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

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

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

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

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

D.____ Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

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

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

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

D.____ Other (please describe):

v.__ Other (please describe):

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

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

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

D.____ Other (please describe):

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

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

2.___ An administrative adjustment was made.

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

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

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

C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

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

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

C.____ Other (please describe):

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

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

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

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

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

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

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

i. State Plan Service trend

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

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

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

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

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

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

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

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

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

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

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

Basis and Method:

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

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

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

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.

4.___ Other (please describe):

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

Basis and method:

1.___No adjustment was necessary
2.___Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

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

Basis and Method:

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

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has

a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

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

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 Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
a. ___Potential Selection bias was measured in the following manner:
b.___The base year costs were adjusted in the following manner:

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

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

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

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

[NOT APPLICABLE] **Special Note for initial combined waivers (Capitated and PCCM) only:**

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

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: 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. *[NOT APPLICABLE]* **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

J. Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments.

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

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

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

DHCS Response

DHCS anticipates additions or revisions to adjustments as we advance in implementation of CalAIM initiatives (e.g., behavioral health payment reform), expand on state budget initiatives, and receive further Legislative direction. DHCS will engage with CMS to amend these adjustments and cost effectiveness calculations as necessary.

a. X State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

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

   The actual trend rate used is:

   DHCS Response

   MCMC and Dental MC: *4.95 percent annually*

SMHS and DMC-ODS: *6.3 percent annually (applies to SMHS, DMC-ODS).*

Please document how that trend was calculated:

DHCS Response

MCMC and Dental MC: *The State's actuaries reviewed the Medi-Cal managed care program experience trend with a focus on the major rate categories over a four-year period (CY 2016 to CY 2019) and the national per capita trend for the four major Medicaid categories of aid (Child, Adult, ACE OE, and SPD) as projected by CMS through CY 2026 in its most recent 2018 actuarial report (https://www.cms.gov/files/document/2018-report.pdf). Based on the review and internal discussion, the actuaries recommended the State use a single PMPM trend of 4.95 percent across all eligibility groups. In developing this single MEG-wide PMPM trend, the actuaries considered the program experience, national PMPM trend for Medicaid populations, CY 2021 capitation rate development trend assumptions, and consideration given the length of the projection period (5-year waiver period). For P1, the State applied a compounded trend factor of 18.42 percent, calculated by compounding the 4.95 percent annual trend over 3.5 years from the midpoint of the base year (January 1, 2019) to the midpoint of P1 (July 1, 2022).*

SMHS and DMC-ODS: *The retrospective year of data includes actual expenditures reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019 for mental health services assigned to the 1915(b) waiver (CA17.R09) and substance use disorder services assigned to the DMC-ODS 1115 demonstration. DHCS reduced these actual expenditures by the amount it identified as costs incurred to provide services to beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims; the amount it spent on substance use disorder services provided to beneficiaries in an IMD; and the amount it spent on substance use disorder services provided to American Indian and Alaskan Native beneficiaries. DHCS trended the result to Prospective Year 1 using the percentage change in the Home Health Agency Market Basket Index to account for inflation. The State Plan Inflation Adjustment for P2 through P5 is equal to the percentage change in the Home Health Agency Market Basket Index from the first quarter of the base year to the first quarter of the projected year.*

2. **X** [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are

predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. **_X_** State historical cost increases *(Applies to MCMC, Dental MC)*.

Please indicate the years on which the rates are based: ***CY 2016 through CY 2019***

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). ***The mathematical method used is year over year exponential smoothing.***

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. ***Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.***

ii. **_X_** National or regional factors that are predictive of this waiver's future costs. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

Please indicate the services and indicators used:

DHCS Response

MCMC and Dental MC: *A five-year annualized prospective PMPM trend (FY2021 to FY2026) as projected by CMS for each major category of aid (Aged, Disabled, Child, Adults, and Expansion Adults) in its 2018 Actuarial Report On The Financial Outlook For Medicaid. The categories of aid encompass a comprehensive level of Medicaid services.*

SMHS and DMC-ODS: *Home Health Agency Market Basket Index*

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs:

DHCS Response

MCMC and Dental MC: *The prospective PMPM trend as projected by CMS for Medicaid on a national basis is considered to be an excellent indicator of future trends over a similar five-year projection period for this waiver's future costs given the large program size and similar types of covered populations and services.*

SMHS and DMC-ODS: *DHCS has found the Home Health Agency Market Basket Index produced by CMS as the most relevant and available predictor of future costs and is used in current payment processes for the SMHS and DMC-ODS delivery systems. CMS uses the Office of the Actuary (OACT) staff on a variety of market basket topics, including index development and construction, theoretical update frameworks, and wage studies which produce actuarially sound indexes.*

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.

DHCS Response

MCMC and Dental MC: *Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.*

SMHS and DMC-ODS: *The PMPM costs per MEG are trended for P1, P2, P3, P4 and P5 utilizing the percentage change in the CMS' Home Health Agency Market Basket (HHAMB) Index for each PY.*

3. **X** The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2. *(Applies to SMHS, DMC-ODS)*

    i. Please indicate the years on which the utilization rate was based (if calculated separately only).

    DHCS Response

    SMHS and DMC-ODS: *DHCS estimated that it would spend an additional $11 million on SUD services provided through a PIHP delivery system to beneficiaries in 10 additional counties in prospective year. DHCS estimated $11 million based upon State Fiscal Year 2019-20 actual expenditures in counties that currently provide SUD services through a PIHP delivery system with populations similar to the 10 counties projected to begin providing SUD services through a PIHP delivery system.*

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

DHCS Response

SMHS and DMC-ODS: *DHCS's estimated cost increase due to change in utilization does not duplicate the inflation cost increase described above. DHCS used the percentage change in the HHAMB index from P1 (CY 2022) to P2 (CY 2023) to estimate the increase in the PMPM due to inflation. California separately calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 ($4,130,795,712*1.0256).*

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

Others:

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

be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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

2. **X** An adjustment was necessary and is listed and described below:
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

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 eligible,
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.__ Changes brought about by legal action (please describe):
For each change, please report the following:
A.___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.___ Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

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

vi. **X** 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. **X** Other (please describe):

DHCS Response

MCMC and Dental MC: *The State applied the following programmatic adjustments:*

1) *Reducing P1 and P2 projected expenditures for the carve-out (from Medi-Cal managed care) of specialty mental health services for a subset of beneficiaries in Sacramento County and Solano County, effective July 1, 2022. Note, these services and populations are included in this waiver under the behavioral health eligibility groups. The impact of the reduction is $16.7 million distributed across applicable eligibility groups and both projection years.*
2) *Increasing P1 projected expenditures for the carve-in (to Medi-Cal managed care) of dental services in San Mateo County, effective January 1, 2022. The impact of the increase is $10.7 million distributed across applicable eligibility groups.*
3) *Reducing P1 projected expenditures for the carve-out of pharmacy services billed on a pharmacy claim, effective January 1, 2022. The impact of the reduction is $6,904.0 million distributed across applicable eligibility groups. As noted previously, effective January 1, 2022, pharmacy and related benefits (listed in Attachment III) that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, medical supplies and enteral nutritional products, as described in the Medi-Cal Rx All Plan Letter (APL 20-020) will be carved out of Medi-Cal managed care capitated benefits. Pharmacy and related benefits that are billed on medical and institutional claims, including physician*

administered drugs, other outpatient drugs, legend, non-legend and specialty drugs, medical supplies and enteral nutritional products, that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020), will remain carved in to Medi-Cal managed care capitated benefits.

4) *Reducing projected expenditures to account for the application of two new rate-setting efficiency adjustments in the waiver period that were not present in the base year. The impact of the reduction is $203.0 million distributed across applicable eligibility groups.*
5) *Increasing P1 projected expenditures for new or expanded covered services such as Major Organ Transplant, Community Health Worker services, Remote Patient Monitoring, Continuous Glucose Monitors, and Dyadic Behavioral Health services, effective January 1, 2022. The impact of the increase is $751.3 million distributed across applicable eligibility groups.*
6) *Increasing P1 projected expenditures for anticipated rate increases associated with addition of Enhanced Care Management as a benefit and the sunset/transition of Whole Person Care Pilots under the CalAIM framework, effective January 1, 2022. The impact of the increase is $565.0 million allocated across applicable eligibility groups.*
7) *Increasing P1 projected expenditures to reflect the ramp-up of the Whole Child Model program, which was not fully phased in during the base year. The impact of the increase is $326.5 million distributed across applicable eligibility groups.*
8) *Adjusting P1, P2, P3, and P4 projected expenditures for new directed payments pursuant to 42 CFR § 438.6(c) that did not exist in the base year, and for increases to directed payments above and beyond annual Consumer Price Index-linked growth. The impact of the adjustment is an increase of $3,509.3 million in P1, $415.0 million in P2, and $75.0 million in P3, and a decrease of $100.0 million in P4, distributed across applicable eligibility groups.*
9) *Increasing P1 projected expenditures for new, time-limited incentive payments pursuant to 42 CFR § 438.6(b) that did not exist in the base year. The impact of the increase is $1,424.8 million distributed across applicable eligibility groups.*
10) *Reducing P2, P3, and P4 projected expenditures for the end of the time-limited incentive payments described above. The impact of the reduction is $38.0 million in P2, $809.3 million in P3, and $577.4 million in P4, distributed across applicable eligibility groups.*
11) *Increasing P2 projected expenditures for the carve-in of long-term care services statewide, effective January 1, 2023. The*

impact of the increase is $2.817.0 million distributed across applicable eligibility groups.

12) *Reducing P2 projected expenditures for the end of the current Managed Care Enrollment Tax. The impact of the reduction is $2,656.3 million distributed across applicable eligibility groups. Increasing P4 and P5 projected expenditures for targeted Medi-Cal provider rate increases for primary care, maternal care, non-specialty mental health, reproductive health, emergency transportation, and home- and community-based services, among others. The impact of the increase is $1,240.0 million in P4 and an additional $2,105.8 million in P5 distributed across applicable eligibility groups.*

The cumulative, weighted-average impact of these adjustments is -0.95 percent in P1, +0.82 percent in P2, -1.20 percent in P3, and 32.32 percent in P4, and 2.11 percent in P5.

Note, for P2, the State applied a −100.0 percent adjustment to the CCI Dual (non-CMC) and CMC eligibility groups, shifted the member months to the SPD Dual eligibility group, and calculated new, weighted-average P1 PMPMs for State Plan Service Costs and Administrative Service Costs.

***SMHS and DMC-ODS:** California included two policy adjustments. In Prospective Year 1, California included a policy adjustment to remove non-pregnancy related services provided to Medi-Cal beneficiaries with unsatisfactory immigration status which were reported on the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports. California removed those expenditures in the September 2020 and December 2020 CMS 64 quarterly reports. In Retrospective Year 2, California included a policy adjustment of .26 percent to account for 10 counties starting to provide substance use disorder services through the PIHP delivery system. The base data calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 ($4,130,795,712*1.0256).*

DHCS added another program and policy adjustment to account for increased costs and utilization for Mental Health Plans and DMC-ODS counties to provide Community-Based Mobile Crisis Intervention Services beginning in January of 2023. DHCS is projecting a PMPM of $1.46 to provide Community-Based Mobile Crisis Intervention Services. DHCS has updated the Policy and

Program adjustment percentages in Cells L33 through L39 on Tab D.5 to account for this increase.

DHCS added another program and policy adjustment to account for increased costs and utilization for a set of Evidence Based Practices (EBP) that are being added to the SMHS delivery system. These EBPs include Assertive Community Treatment (ACT), Forensic ACT (FACT), Supported Employment, Clubhouse, Coordinated Specialty Care, and Enhanced Community Health Worker Services. Counties will be able to start opting in to provide these services in P4. DHCS is projecting a PMPM increase of $1.95 in P4 and an increase of $1.87 in P5. DHCS has updated the Policy and Program adjustment percentages in Cells L66 through L72 for P4 and L82 through L88 for P5 on Tab D.5 to account for this increase.

DHCS added another program and policy adjustment to account for increased costs and utilization for a set of Evidence Based Practices (EBP) that are being added to the SMHS delivery system. These EBPs include Assertive Community Treatment (ACT), Forensic ACT (FACT), Supported Employment, Clubhouse, Coordinated Specialty Care, and Enhanced Community Health Worker Services. These EBPs provide currently covered services through specific program models. The currently covered services include Physician Services (including Psych), Other Practitioners (Including Psych), and Targeted Case Management. Counties will be able to start opting in to provide these services in P4. DHCS is projecting a PMPM increase of $1.95 in P4 and an increase of $1.87 in P5. DHCS has updated the Policy and Program adjustment percentages in Cells L66 through L72 for P4 and L82 through L88 for P5 on Tab D.5 to account for this increase. DHCS also provided documentation of the trend rate projections in the Trend Data tab, including the annualized cost at full-ramp up and statewide opt-in assumptions.

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. *(Applies to MCMC, Dental MC, DMC-ODS)*

1.___ No adjustment was necessary, and no change is anticipated.

2.__X__ An administrative adjustment was made. *(Applies to MCMC, Dental MC, DMC-ODS)*

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

ii.__X__ Cost increases were accounted for. *(Applies to MCMC, Dental MC, DMC-ODS)*

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.__X__ Other (please describe) *(Applies to MCMC, Dental MC, DMC-ODS)*:

DHCS Response

MCMC and Dental MC: *DHCS calculated a 5.39 percent trend rate based on the average of annual salary cost increases over a two-year period (SFY 2017-18 and SFY 2018-19) for program areas within DHCS that are directly responsible for the operation of the Medi-Cal managed care delivery system. For P1, the State applied a compounded trend factor of 20.17 percent, calculated by compounding the 5.39 percent annual trend rate over 3.5 years from the midpoint of the base period (January 1, 2019) to the midpoint of P1 (July 1, 2022).*

DMC-ODS: *DHCS anticipates 10 counties not currently participating in DMC-ODS will be joining in Prospective Year 2. Their participation in DMC-ODS will increase total administrative costs anticipated to be approximately $902,000 or an increase from .26% to .28% program adjustment percentage.*

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

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

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

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

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.__ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. 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: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

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

e.___ **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG 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):

- 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.

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

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

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

3.___ Other (please describe):

4.___ No adjustment was made.

5.___ 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.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
    1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

        DHCS Response

        MCMC and Dental MC: *In P2, the State is projecting an increase in member months for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., COHS and CCI counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).*

        Also in P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.

        No additional caseload changes are projected for purposes of the cost-effectiveness calculation, as described in Section D, Part I.E. Appendix D1 – Member Months.

        SMHS and DMC-ODS: *The rate of change identified in Column I is due to inflation adjustments and program policy change. The rate of change from R2 to P1 is 4.5 percent. This is due to an inflation adjustment of 6.3*

percent and policy change adjustment of related to the removal of non-pregnancy claims for beneficiaries with unsatisfactory immigration status. The inflation adjustment of 6.3 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending June 30, 2019, which is the last quarter in Retrospective Year 2 (Fiscal Year 2018-19), to the quarter ending March 31, 2022, which is the first quarter of Prospective Year 1 (Calendar Year 2022). The program policy change adjustment is equal to the amount of non-pregnancy claims for beneficiaries with unsatisfactory immigration status ($58,985,535.98) divided by the expenditures for mental health and substance use disorder services reported in the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports ($4,130,795,712.28).

The rate of change from P1 to P2 is 3.2 percent. This is due to an inflation adjustment of 2.6 percent and program policy change adjustment of .26 percent. The inflation adjustment of 2.6 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending March 31, 2022 (1st quarter of Calendar Year 2022) to the quarter ending March 22, 2023 (1st quarter of Calendar Year 2023). The program policy change adjustment of .26 percent accounts for 10 additional counties starting to provide substance use disorder services through a PIHP delivery system. California estimated the cost of those additional 10 counties would be $11 million based upon costs incurred by counties with similar populations in Fiscal Year 2019-20. California divided $11 million by the R2 expenditures trended forward to Fiscal Year 2019-20 using the percentage change in the Home Health Agency Market Basket Index.

The rate of change from P3 to P4, and P4 to P5 is entirely due to an inflation adjustment. The inflation adjustment for each year is equal to the percentage change in the Home Health Agency Market Basket Index from the 1st quarter of the base year to the 1st quarter of the prospective year.

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**:

DHCS Response

MCMC and Dental MC: *The State refers to the descriptions of the State Plan Services trend in Section D.I.J.a, the State Plan Services programmatic adjustments in Section D.I.J.b, and the Administrative Cost adjustment in Section D.I.J.c.*

SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes an inflation adjustment. The inflation adjustment captures anticipated changes in unit costs.*

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**:

   DHCS Response

   MCMC and Dental MC: *The State refers to the descriptions of enrollment-related considerations in Section D.I.E.c, the State Plan Services trend in Section D.I.J.a, and the State Plan Services programmatic adjustments in Section D.I.J.b.*

   SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes three program policy change adjustments. These three program policy change adjustments capture anticipated changes in utilization.*

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.