Utah Medicaid Payment and Service Delivery Reform

1115 Waiver Request

Submitted by:
Utah Department of Health
Division of Medicaid and Health Financing

New Waiver Application

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Payment and Service Delivery Reform
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Section I Introduction, and Program Description

A. Background, Introduction, and Program Description

It is no secret that medical costs continue to rise. In Utah Medicaid, growth rates have exceeded the State's annual revenue growth rate for the past two decades. Accordingly, the State is concerned about the long-term sustainability of the Medicaid program. While Medicaid is a unique entitlement health care program that has various federal mandates and regulations associated with it, much of the increased costs are due to conditions prevailing in the health care industry as a whole. Health care industry costs continue to outpace overall inflation due to many factors, among those is a reimbursement structure that provides financial incentives for overutilization of health care services. In an effort to preserve the long-term viability of the Medicaid program and to establish a standard for better control over increasing costs in health care, the State of Utah is submitting this Medicaid reform proposal that implements payment reforms and more appropriately aligns financial incentives in the health care system. Not only will the financial incentives change, but the quality of health care will be maintained or enhanced.

In its 2011 General Session, the Utah State Legislature passed Senate Bill 180, Medicaid Reform. This new statute provides Utah's Single State Agency, the Department of Health, with overall guidance and direction for creating and submitting this waiver proposal. In addition, it contains provisions that grant Utah Medicaid preferential funding consideration when expenditures are less than appropriated funding or historical growth rate targets. The residual amount is deposited into a newly created "Medicaid Growth Reduction and Budget Stabilization Account" (Stabilization Account). In circumstances in which the amount of general fund growth available for Medicaid and the balance in the Stabilization Account are insufficient to meet the growing needs in the program, then the State would implement service reductions from a prioritized list of health services as has been done in the Oregon Medicaid program.

1. Accountable Care Organizations (ACOs)

The State of Utah has contracted with managed care organizations under a variety of different contracting arrangements over the past two decades. While the State believes that these contracts have added value in delivering quality care to Medicaid clients in controlling costs over the years, the State also believes that converting these contracts to an Accountable Care Organization (ACO) contract model can better align financial incentives to control costs and to deliver appropriate care to clients. This reform proposal will replace the current Utah Medicaid managed care model with the Utah Medicaid

ACO model. The Utah Medicaid ACO model is distinct from the model adopted by the Medicare program. For the purposes of its Medicaid program, the State is willing to consider as an ACO any organization that can (1) manage risk and accept a capitated premium for its services, (2) distribute payments across the continuum of scope of service providers and (3) meet the quality standards required under contract.

The ACO contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment and create an environment in which the ACOs deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved. ACOs would also have more flexibility to distribute payments throughout their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. The ACO also could choose to distribute incentive payments through its network of providers when various cost-containment, quality or other goals are met. By reforming payments at each level of health care delivery, the ACO will better align the incentives for all participating providers.

While an ACO model may at first seem quite similar to a traditional managed care, the key differences are (1) that the ACO payments eliminate the incentives to provide excess care and (2) the contracts will be maintained only if the ACO meets established quality and access criteria.

A centerpiece of the ACO care delivery model is a "Medical Home." Each Medicaid client would have access to a primary care provider or a group of primary care providers who would deliver care and also coordinate the client's use of medical services throughout the ACO network of providers. The client would be expected to utilize services within the ACO provider network. Each ACO would create, through contract or employment, a sufficient network of health care providers to deliver the necessary care for the enrolled Medicaid clients. Medicaid clients would be able to select from at least two ACOs at their time of initial program enrollment and have an option once per year of switching health plans during an "open enrollment" period.

2. Risk Adjusted, Capitated Payments

The State plans to use risk-adjusted, capitated payments for all of its Accountable Care Organization contracts. These payments consist of actuarially certified rates based on major categories of Medicaid eligibility (i.e., children, pregnant women, elderly, etc.) and the severity of illness prevalent in the enrolled population.

Actuarial certification of rates is made by actuaries who calculate historic cost and trend amounts for enrollees' health care utilization in the various categories of eligibility. These calculations are based on claims and/or encounter data from the providers delivering the care.

The State wants to ensure that after the initial round of actuarial rate setting has been completed for the implementation of this reform, that the resulting capitated rates can serve as the baseline for future years' reimbursement rates. As a foundational principle of this reform, the State wants to eliminate the incentive for providers to deliver care based on reimbursable or billable services. As a result, the State wants and expects that ACOs and their associated providers will begin delivering care in a manner that will not result in as many billable services being delivered. However, under the current actuarial rate setting process, this could result in ongoing reductions in reimbursement rates. Consequently, the State has worked with its contracted actuaries to develop a data gathering model that will meet the needs of the new ACO structure, while still meeting the relevant rate-setting regulations.

3. Funding and Special Consideration

In the implementation of this reform proposal, the State is interested in keeping the current provider reimbursement levels intact. There is no interest in reducing the reimbursement levels for providers willing to venture into this new reform proposal with the State. In general, the State envisions retaining the current level of Medicaid funding in the system and realign incentives with the expectation that future program growth will be more comparable with State revenue growth.

One way the State supports current reimbursement levels is a hospital provider assessment. Additionally, the State makes supplemental payments to its teaching hospital. The State wants to make sure that the federal funding associated with these payments is not jeopardized as a result of this reform proposal's use of ACOs. The State will restructure its hospital assessment base and place the majority of the previous quarterly distribution payments into the new ACO capitated rates.

4. Budget Management Strategy

One of the overall goals of this reform is to bring Medicaid growth more in line with overall State revenue growth. In addition to the reform proposal's conversion to ACO contracts is a budget management strategy that sets specific Medicaid growth targets. Those targets would be linked to long-term State revenue growth figures.

It is the intent of the State that in years when Medicaid's growth was not as high as the targets that the difference would be deposited into the Medicaid Growth Reduction and Budget Stabilization Account. In years when Medicaid growth exceeds general fund growth targets, then the State would like to use a plan similar to that used by the Oregon Medicaid program to reduce benefits on a pre-determined schedule.

5. Out-of Network Payment Limitations

Another way to reduce health care costs is to place limits on out-of-network charges for Medicaid clients. Currently, when an individual seeks urgent care out of his or her selected managed care network, the treating provider will charge the client's health plan a

higher fee. This reform proposal seeks to place limits on such charges for Medicaid clients.

6. ACO Scope of Benefits

The current Utah Medicaid managed care contracts generally include only inpatient hospital, outpatient hospital, physician services and other ancillary services. Pharmacy, dental, mental health and long-term care services are "carved out" of or excluded from these contracts. The reform proposal looks to include non-behavioral health pharmacy benefits in the ACO benefit package. The State believes that including these pharmacy benefits in the ACO scope of services will better align the incentives of prescribers with the goals of the State.

7. Quality of Care Standards

Utah Medicaid also intends to maintain quality of care monitoring of the ACOs through the continued use of HEDIS data. The agency will utilize existing processes and procedures which have been established and guided by federal regulation applicable to managed care organizations. In addition, in order to renew a contract authorized under this 1115 Waiver, the ACOs will be required to participate in quality improvement activities and adhere to metrics specific to an ACO as yet to be developed with input from providers and client advocates as coordinated and promulgated by the Utah Department of Health.

8. Individual Accountability and Responsibility

This proposal seeks to engender an enhanced sense of responsibility and accountability on the part of Medicaid clients. Medicaid clients should participate more in the cost of their health care. The State is interested in replacing archaic limits on Medicaid copayment amounts.

9. Client Incentives

An important aspect for enhancing physical well-being and reducing service utilization is patient compliance with recommended treatment. Increasing patient compliance results in better outcomes, lower costs and long term stabilization of chronic conditions. This proposal would allow an ACO to offer some incentives that will help increase patient compliance for victims of chronic disease states. Two of these proposed incentives would be (1) limiting or waiving copayments and (2) granting limited cash awards for compliant behavior, which reduces the need for additional service.

10. Premium Subsidy Option

Under a federal waiver, the State currently offers a health insurance premium subsidy to low-income individuals who are not eligible for Medicaid coverage. Medicaid-eligible individuals do not have the option to enroll in this premium subsidy program. This

reform proposal seeks to allow a Medicaid client the option to receive a premium subsidy and purchase a health insurance product through the State's Health Insurance Exchange as an alternative to enrolling in the Medicaid ACO product.

11. Geographic Implementation

The State currently has three managed care organizations providing services to Medicaid clients in the State's four most populous counties: Salt Lake, Davis, Utah and Weber. The reform proposal looks to implement the ACO contracting model in these same four counties.

12. Waiver Authority

The State currently has a 1915(b) Freedom of Choice Waiver, Utah Choice of Health Care Delivery Program. The State seeks to replace the current waiver with this 1115 proposal. Although the current 1915(b) waiver will be superseded and replaced, this 1115 proposal also seeks to retain many of the current 1915(b) waiver provisions, as those features are essential to the operation of the new waiver. Adapting the existing 1915(b) waiver for this proposal is not feasible due to selected aspects requiring 1115 waiver authority. This proposal is necessary in order to: (a) incorporate the use of premium subsides as a client option to purchase health insurance through the exchange, and (b) allow flexibility in increasing copayments and allowing client incentives.

13. Implementation Time Frames

The proposed date for implementation is **July 1, 2012**. This timetable should allow the State and health care providers some planning and implementation time for realigning models of care delivery and updating payment and monitoring systems. Therefore, the State requests timely consideration for this proposal.

14. Goals and Objectives

The primary goal of this reform proposal is to significantly reduce the rate at which Utah Medicaid expenditures are increasing. Stated another way, reduce the slope of the curve reflecting the rate of increasing expenditures. Similarly, a companion goal is that expenditures under the ACO model would be measurably less than what otherwise would have been by retaining the current system.

Another main goal of the reform is to align incentives in such a way that the delivery patterns move away from billable events and to focus more on patient outcomes and the quality of care.

What the Utah proposal does is incorporate what is working well in the current system, adds new innovative aspects, and modifies the delivery and reimbursement system to conform to the ACO model.

Section II Proposed Health Care Delivery System

Part 1: Program Overview

A. Introduction

Section I of this waiver request contains a comprehensive program description, which includes and explains the anticipated delivery system. The State seeks to replace the current 1915(b) Freedom of Choice Waiver, Utah Choice of Health Care Delivery Program that has been in place since 1982, with this 1115 proposal. Although the current 1915(b) waiver will be superseded and replaced, this 1115 proposal seeks to retain many of the current 1915(b) waiver provisions, as these features are essential to the operation of the new waiver. Adapting the current waiver is not feasible due to selected aspects, which only an 1115 waiver can accommodate. The 1115 waiver request is necessary to incorporate the use of premium subsidies as a client option to purchase health insurance through the exchange and to allow flexibility in copayments and incentives.

Since many characteristic of the current 1915(b) waiver are critical to the new 1115 proposal, and in order to facilitate communication and understanding, the State has adapted and modified the 1915(b) waiver preprint. This modified format contains and explains the aspects and provisions essential to the implementation of the ACO model. These characteristics include: scope of service, eligibility populations, marketing, enrollment, operations, monitoring, assurances, etc. Integrated within this structured format are the special provisions which only an 1115 waiver will accommodate.

Accordingly, in order to facilitate communication, and promote effective understanding, the State of Utah has chosen to submit this waiver request for its proposed health care delivery system (ACO) by adapting and modifying the format for the currently approved 1915(b) Freedom of Choice Waiver, Utah Choice of Health Care Delivery Program.

Disease Management Program and the 1115 Waiver Application

In July 1998, the State implemented the Hemophilia Case Management Program under a modification to the Utah Choice of Health Care Delivery Program. The purpose of the modification was to allow DMHF to contract with a licensed pharmacy for the provision of anti-hemolytic factors to Utah's Medicaid clients with hemophilia. In addition, a disease management system was implemented to ensure a more effective level of monitoring and improve client access to higher quality.

On August 7, 2007, CMS approved the State's proposed State Plan Amendment (SPA) Transmittal Number 05-019. This SPA was effective October 1, 2005 and established Hemophiliac Disease Management Services, through Preventative Services 42 CFR 440.130(c). As a result, the program is now called the Hemophilia Disease Management Program. The State seeks to maintain this management program under the authority of the State Plan. Even though clients will be offered their choice of ACO, Utah seeks to continue the Hemophilia Disease Management Program, as approved in the current

1915(b)(4) waiver, in this 1115 Waiver. Due to the success of the disease management program, individuals with hemophilia or other disease states, as noted below, can choose any ACO, but clients will be managed and their drug costs paid through the disease management program.

The State is pursuing the implementation of other disease management programs to be included in this 1115 Waiver. The other disease states being added in this 1115 Waiver are:

- Multiple Sclerosis
- Cystic Fibrosis
- Rheumatoid Arthritis
- Chohn's Disease
- Hepatitis

B. Statutory Authority

1. Waiver Authority.

The State's waiver program will be authorized under section 1115 of the Act. Specifically, the State is also relying upon authority provided in the following subsection(s) of section 1915(b) of the Act:

1915(b)(2) - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing ACOs in order to provide enrollees with more information about the range of health care options open to them.

1915(b)(4) – The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

- Choices
- Hemophilia Program

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

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

X FFS Selective Contracting program (please describe)
Hemophilia Disease Management Program: The State has a contract with a Utah licensed pharmacy

2. Sections Waived.

Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act:

a. Section 1902(a)(1) - Statewideness

This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. Section 1902(a)(10)(B)

Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c. Section 1902(a)(23)

Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an ACO.

3. Utah Medicaid Premium Assistance Program

The Department proposes to create a premium assistance option for Medicaid enrollees who choose to purchase and enroll in health insurance rather than enrolling in a Medicaid ACO.

Eligibility
All enrollees must meet eligibility criteria for Medicaid. No changes will be made to any Medicaid eligibility requirements that are more restrictive than those in effect on March 23, 2010.

The state will assure that:

a. Adults who have been determined eligible for Medicaid are given an opportunity to receive premium assistance for ESI, COBRA or private non-group coverage in lieu of enrolling in an ACO.

b. Families with dependent children that are eligible for Medicaid may elect to have their children receive premium assistance for

ESI, COBRA or private non-group coverage, instead of enrolling in a Medicaid ACO.

The State will establish and maintain procedures (which may be done through rulemaking) that will:

a. In the case of ESI, ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium assistance subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving Medicaid premium assistance from the State;

b. Provide written information prior to enrollment in Medicaid Premium Assistance explaining the differences in benefits and cost sharing between direct Medicaid coverage and ESI, COBRA or Private non-group coverage, so that they can make an informed choice;

c. Allow individuals to opt out of premium assistance and receive Medicaid coverage during the open enrollment of ESI, COBRA, or private group coverage.

d. Allow children to opt out of premium assistance and begin receiving Medicaid or CHIP coverage at any time, with an immediate effective date upon request;

e. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI, COBRA or private non-group coverage and the individual's/family's share of the premium;

f. Require enrollees to notify the Utah Department of Health within 10 days if they change their ESI, COBRA or private non-group plan, there is a change in the amount of their premium, or their ESI, COBRA or private non-group coverage is terminated; The Department will ensure that the total amount of Medicaid Premium Assistance provided to an individual or family does not exceed the amount of the individual's or family's financial obligation toward their ESI, COBRA or private non-group coverage;

g. Provide for recovery of payments made for months in which the individual or family did not receive ESI, COBRA or private non-group coverage. The Federal share must be returned within the timeframes established in statute and regulations; and

h. Provide for a redetermination of eligibility at least once every 12 months.

Choice of Benefit Plans.

An eligible individual or family may enroll in any qualified insurance plan that meets the requirements specified in State rules and is provided:

a. by their employer; or

b. to which they have access through COBRA

An eligible individual or family may enroll in any qualified plan available through Utah's Health Insurance Exchange.

Qualified Plan Criteria

A Medicaid Premium Assistance Qualified Health Plan means a health plan, which meets all of the following criteria:

a. Health plan coverage includes:

(i) physician visits;

(ii) hospital inpatient services;

(iii) pharmacy services;

(iv) well child visits; and

(v) children's immunizations.

b. The deductible may not exceed $2,500 per individual.

c. The plan must pay at least 70% of an inpatient stay after the deductible.

d. The plan does not cover any abortion services; or the plan only covers abortion services in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of rape or incest.

Cost Sharing

Adults and children of families that choose premium assistance will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium assistance will be charged cost sharing amounts set by their qualified plan and will not be limited to the title XIX five percent (5%) out-of-pocket family income maximum. All other cost sharing, including co-payments, and co-

insurance, are set by the qualified plan and are the responsibility of the enrollee.

ESI and COBRA Delivery Systems.

Medicaid clients who choose to receive premium assistance will receive services through the delivery systems provided by their respective qualified plan.

Disenrollment from the Premium Assistance Program.

Adults and children who disenroll from Medicaid premium assistance and continue to meet Medicaid eligibility requirements will be seamlessly enrolled in the direct coverage Medicaid program. Medicaid will immediately enroll these individuals regardless if enrollment is outside the annual ACO plan choice period to ensure that there is no break in coverage.

Children who disenroll from Medicaid premium assistance and are no longer eligible for Medicaid but are eligible for CHIP will be seamlessly enrolled in direct coverage CHIP. CHIP will ensure that there is no break in coverage.

Adults who disenroll from Medicaid premium assistance and are no longer eligible for Medicaid but are eligible for the Primary Care Network (PCN) will be seamlessly enrolled in PCN. PCN will ensure that there is no break in coverage.

Reimbursement Methodology

The Department will determine the appropriate MEG for each Medicaid eligible individual in the household. The maximum amount of premium assistance payable to the individual or family may not exceed the total cost of the actuarially certified PMPM capitation rate for the State's lowest cost ACO for each eligible member had they chosen to be enrolled in direct coverage. The premium assistance subsidy will be paid directly to the individual / family up to the maximum amount specified above.

Dental Benefits

Dental benefits for children and pregnant women will be offered through two paths. If the health benefit package that is available to a child or pregnant woman through qualified premium assistance coverage includes dental benefits, the child's or pregnant woman's premium assistance will be approximately equivalent to the per-person-per-member monthly cost or the appropriate rate cell under the title XIX State plan including dental costs.

If a child or pregnant woman does not receive dental benefits through the qualified premium assistance plan, the enrollee shall receive dental coverage directly through Medicaid.

C. Delivery Systems

1. Delivery Systems.

The State will be using the following systems to deliver services:

ACO: Risk-comprehensive contracts are fully capitated and require that the contractor be an ACO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section.

2. Procurement.

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

ACO: X **Open** cooperative procurement process (in which any qualifying contractor may participate)

D. Choice of ACOs

1. Assurances.

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

2. Details.

The State will provide enrollees with two or more ACO's.

E. Geographic Areas Served by the Waiver

1. General

The health care delivery system will be limited to the most populous counties located along the Wasatch Front in the State.

2. Details.

The chart below lists the counties that will be participating in the waiver.

City/County/Region	**Type of Program (PCCM, MCO, PIHP, PAHP or other entity)**	**Name of Entity (for MCO, PIHP, PAHP, or other entity)**
Davis County	ACO	TBD
Salt Lake County	ACO	TBD
Weber County	ACO	TBD
Utah County	ACO	TBD

F. Populations Included in Waiver

Eligibility categories of included populations and excluded populations are shown below:

1. Included Populations.

The following populations are included in the Waiver Program:

a. Section 1931 Children and Related Populations

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

X Mandatory enrollment
___ Voluntary enrollment

b. Section 1931 Poverty-level Pregnant women.

X Mandatory enrollment
___ Voluntary enrollment

c. Blind/Disabled Adults and Related Populations

are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. (Blind/Disabled Adults who are age 65 or older are reported in this category, not in Aged.)

X Mandatory enrollment
___ Voluntary enrollment

d. Aged and Related Populations

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

X Mandatory enrollment
___ Voluntary enrollment

e. Foster Care Children

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

X Mandatory enrollment
___ Voluntary enrollment

2. Excluded Populations.

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

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

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

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

__X__ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

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

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

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

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

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

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

_X_ Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

_X_ Other (Please define):

- Section 1931 non-pregnant adults age 19 and older and related poverty level populations,* also known as Utah's PCN population
- Individuals age 19 and older who qualify for Medicaid by paying a spenddown and who are not aged or disabled*
- Individuals residing in the Utah State Hospital or the Utah Developmental Center
- Individuals who voluntarily enroll with the Healthy Outcomes Medical Excellence (HOME) Program

*These individuals are covered under the Section 1115 Demonstration for the Primary Care Network of Utah. In the 1115 Demonstration for the Primary Care Network of Utah the enrolled groups are referred to as TANF adults, Transitional Medicaid adults, and Medically needy adults.

G. Services

A list of all services to be offered under the Waiver is also included in the section that details Cost-Effectiveness .

State Plan Services		All MEGS	
Service Category	State Plan Approved Services	Accountable Care Organization Risk Reimbursement	FFS services Impacted by ACO
Day Treatment Services	X		
Dental	X		
Detoxification	X	X	
Durable Medical Equipment	X	X	
Emergency Services	X	X	
EPSDT	X	X	
Family Planning Services	X	X	
Federally Qualified Health Center Services	X	X	
Home Health	X	X	
Hospice	X	X	
Inpatient Hospital - Psych	X		
Inpatient Hospital - Other	X	X	
Immunizations	X	X	
Lab and X-Ray	X	X	
Mental Health Services	X		
Nurse Midwife	X	X	
Nurse Practitioner	X	X	
Nursing Facility (SNF greater than 30 days)	X		
Obstetrical Services	X	X	
Occupational Therapy	X	X	
Audiology	X	X	
Diabetes Self-Management Education	X	X	
Dialysis	X	X	
Early Intervention	X		
Enhanced Services to Pregnant Women	X	X	
Podiatry	X	X	
Disease Management (Hemophiliacs only)	X	X	
Other Psych Service	X		
Outpatient Hospital - All Other	X	X	
Outpatient Hospital - Lab and X-Ray	X	X	
Personal Care	X	X	

Pharmacy - excludes mental health drugs and immunosuppressants - hemophilia drugs limited to single provider under 1915(b)(4) authority	X	X	X
Physical Therapy	X	X	
Physician	X	X	
Private Duty Nursing	X	X	
Prof. & Clinic and other Lab and X-Ray	X	X	
Psychologist	X		
Rural Health Clinic	X		
Speech Therapy	X	X	
Substance Abuse Treatment Services	X		
Testing for Sexually Transmitted Diseases	X	X	
Transportation - Emergency	X		
Transportation - Non-Emergency	X		
Vision Exams and Glasses	X	X	
Aging Waiver	X		
DD/MR Waiver	X		
Tech Dependent Waiver	X		
Brain Injury Waiver	X		

1. Assurances.

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

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

X **The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

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

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

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

2. Emergency Services.

In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an ACO will have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

3. Family Planning Services.

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

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

X The ACO will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

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

__ Other (please explain):

__ Family planning services are not included under the waiver.

4. FQHC Services.

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

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

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

State's Response: The State will monitor the ACOs to ensure that each has at least one participating FQHC.

5. EPSDT Requirements.

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

6. 1915(b)(3) Services.

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

7. Self-referrals.

X The State requires ACOs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the ACO contract:

State's Response:

- emergency care;
- family planning;
- for female enrollee's, health plans must allow direct access to women's health specialist within the health plan's network for covered care related to women's routine and preventive care; and
- for enrollees determined to need a course of treatment or regular care monitoring, the health plans must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition.

H. Provider and Client Incentive

An important aspect for enhancing physical well-being and reducing service utilization is patient compliance with recommended treatment. Increasing patient compliance results in better outcomes and long term stabilization of chronic conditions. Accordingly, the consumer advocate and provider workgroup recommended that Accountable Care Organizations offer some incentives that will help increase patient compliance for Medicaid clients with chronic disease states.

Some suggestions from the workgroup were long term strategies, while others could be implemented in the near future. One overriding and guiding principle was that the interests of the patients and the ACOs are best served by increasing compliance through augmenting flexibility in what incentives could be offered and how those incentives are implemented. Another important principle was that of relying on incentives rather than employing disincentives or punishment to the recipients.

The workgroup also came to a consensus in that each ACO should have some flexibility to design its own incentive program within specified parameters. As each ACO would have a risk contract, it would be in its best interest to promote compliant behavior, thereby reducing the need for additional services. Conversely, competition among plans could also be enhanced by offering different packages of incentives, which could be tailored toward differing client needs.

The State requests that the following incentives be approved as part of the 1115 waiver:

1. Waiving or reducing copayments for specific services,
2. Granting limited cash incentives for very specific client behavior,
3. Awarding gift cards for very specific client behavior,

4. Loaning specific items, in limited circumstances, that would engender compliance and monitoring in serious situations (e.g., cell phones).

As in the case of cash grants, these incentives would have very defined limits. This limited funding would come through state and federal matching funds.

As for small gift cards, they would be funded by the various ACOs based upon anticipated savings generated by compliant clients. The same provision would apply to monitoring devices such as cell phones. Similarly, the cost of waiving or reducing copayments for specific services or an array of services would also be borne by the participating ACOs.

These workgroup recommendations were carefully considered. The incentives were based upon what, in all likelihood, would motivate client compliance, while at the same time being cognizant of the perception which may occur by offering enticements to Medicaid recipients.

I. Cost Sharing for Accountable Care Organization Clients

In workgroup meetings with client advocates and representatives from potential ACOs and other providers, cost sharing was a topic of discussion. The sense stemming from the workgroup was that in order to appropriately manage resources, reinforce client responsibility, and to foster a competitive environment among ACOs, there must be some flexibility in cost sharing beyond what is currently in 42 CFR 447.50 through 447.60. However, there is also the sense that cost sharing must be reasonable given the demographics and economic status of Medicaid clients.

Accordingly, this waiver application seeks to implement a cost sharing policy that is similar to what currently exists in the Utah CHIP program under Plan B. The table below represents the maximum cost sharing amounts. Further, there is a cost sharing cap of 5 percent of the family's gross annual income. There will be no cost sharing for those having zero income. Also, there would be no cost sharing for individuals who have a verified or pending American Indian or Alaska Native status on their eligibility record, and have an established relationship with one of the following types of facilities: Indian Health Service facilities, Tribal clinic, or Urban Indian Organization facility.

As mentioned earlier, representatives from potential ACOs would use this increased copayment flexibility to generate competition among plans. This competition would occur in the marketing of the various plans. For example, ACOs could adopt lesser copays than shown above. Depending on the copay structure, one organization could offer across the board reductions in copayments while another may reduce copayments on selected services or visits.

ACO Copayment Summary

BENEFITS (per plan year)	CO-PAYMENT
OUT-OF-POCKET MAXIMUM	5% of family's annual gross income
MEDICAL BENEFITS	
DEDUCTIBLE	$40/family, annually
WELL-CHILD EXAMS	$0
IMMUNIZATIONS	$0
DOCTOR VISITS	$5
SPECIALIST VISITS	$5
EMERGENCY ROOM	$15 per visit for an emergency and $25 per visit for a non-emergency
AMBULANCE	5% of approved amount after deductible
URGENT CARE CENTER	$5
AMBULATORY SURGICAL & OUTPATIENT HOSPITAL	5% of approved amount after deductible
INPATIENT HOSPITAL SERVICES	$220 after deductible
LAB & X-RAY	$0 for minor diagnostic tests and x-rays; 5% of approved amount after deductible for major diagnostic tests and x-rays
SURGEON	5% of approved amount
ANESTHESIOLOGIST	5% of approved amount
PRESCRIPTIONS - Preferred Generic Drugs - Preferred Brand Name Drugs - Non-Preferred Drugs -	 $5 5% of approved amount 10% of approved amount
PHYSICAL THERAPY	$5
CHIROPRACTIC VISITS	5% of approved amount after deductible
HOME HEALTH & HOSPICE CARE	5% of approved amount after deductible
MEDICAL EQUIPMENT & MEDICAL SUPPLIES	5% of approved amount after Deductible
DIABETES EDUCATION	$0
VISION SCREENING	$5
HEARING SCREENING	$5

J. Service Priority

In circumstances in which the amount of general fund growth available for Medicaid and the balance in the Stabilization Account are insufficient to meet the growing needs in the program, then the State would implement service reductions from a prioritized list of health services similar to what has been done in the Oregon Medicaid program. As such, the currently approved benefit packages for Traditional and non-Traditional Medicaid enrollees would be the starting point for the application of a prioritized list of health services.

In order to establish a priority list, the State of Utah would require waivers of: Freedom of Choice, Statewideness, Amount Duration and Scope of Services, and provisions relating to the Early Periodic Screen Diagnosis and Treatment program. In other parts of this 1115 waiver request, the State has already requested waivers for Statewideness and Freedom Choice. Accordingly, the State also requests waivers of the following provisions:

Amount, Duration and Scope of Services

Section 1902(a)(10)(A) and Section 1902(a)(10)(B)
42 CFR 440.230-250

A waiver of this provision would enable the State to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the State Plan to mandatory Medicaid eligibles, to enable the State to limit the scope of services for optional and expansion eligibles.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Section 1902(a)(10)(A) and Section 1902(a)(43)(C)

A waiver of this provision would allow the State to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The State must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening.

Part 2: Access

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

A. Timely Access Standards For ACOs

Assurances for ACO programs.

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

X The CMS Regional Office will reviewed and approved the ACO contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services**. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

B. Capacity Standards

Assurances for ACO programs.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services**. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACO.**

C. Coordination and Continuity of Care Standards

1. Assurances For ACO programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care**. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

2. Details on ACO enrollees with special health care needs.

The following items are required.

a. Identification.

The State has a mechanism to identify persons with special health care needs to ACOs, as those persons are defined by the State. Please describe.

State's response: Throughout the current waiver period, the State produced reports for each managed care plans that listed children who were in a "disabled" rate cell, in foster care, receiving adoption assistance, or receiving services under a home and community-based waiver. These lists of children included each child's Medicaid ID number, address, and when they were enrolled with the managed care plan. As of July 1, 2007 the managed care plans have the capability to produce the above reports using the State's Medicaid Managed Care System. Under this 1115 Waiver request the state will continue this process.
End of State's response.

b. Assessment.

Each ACO will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

State's response: The ACOs will use health needs assessment tools to identify clients with special needs. The tool will be used for all new enrollees and covers areas regarding disabilities, specific medical conditions (heart disease, diabetes, asthma, hypertension, chronic pain, functional status, etc. Those identified as having special needs are then referred to case management staff (RNs) who then determine if a more detailed assessment is needed. The ACOs are required to have other ongoing mechanisms in place to identify existing enrollees with special needs. This allows the ACO to identify members who were not identified as having special needs at initial enrollment but later, if their health needs change. Examples of ongoing mechanisms include analysis of claims for certain diagnostic procedure codes, concurrent review of inpatient care, and referrals from PCPs or discharge planners. Once identified, these cases are referred to care coordinators who perform more detailed needs assessments.
End of State's response.

c. Direct access to specialists.

If treatment plan or regular care monitoring is in place, the ACO has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Part 3: Quality

Assurances for ACOs programs.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. Further**,** the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.

X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each ACO contract.

Part 4: Program Operations

A. Marketing

Marketing includes indirect ACO administered marketing (e.g., radio and TV advertising for the ACO in general) and direct ACO marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities**. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

2. Details

a. Scope of Marketing

The State does not permit direct or indirect marketing by ACOs.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements**. Further, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

2. Details

a. Non-English Languages

X Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

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

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. **X** The languages spoken by approximately **5** percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

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

State's response: The ACOs will clearly state in their member handbooks that oral interpretation is available for all languages at no charge to the enrollee including how the enrollee may request the oral translation.

End of State's response.

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

State's response: Every new applicant for Medicaid in the urban counties is offered an orientation about Medicaid and the Choice of Health Care Delivery Program. This process will continue under the authority of this new 1115 Waiver program. A Health Program Representative (HPR) employed by the Medicaid agency conducts the orientation. During the orientation the potential enrollee is presented with the health plan options, services covered by the plans, an explanation of services not covered by the plans and how to obtain them, how to receive primary care, how to appropriately use emergency rooms, and how to access family planning under this waiver program. A detailed booklet is given to all potential enrollees describing managed care.

See Medicaid's *Medicaid Member Guide* by clicking on the link below: http://health.utah.gov/umb/forms/pdf/expmed.pdf

The Medicaid Member Guide will be updated to refer to the new ACOs effective July 1, 2012.

End of State's response.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:
X State
___ contractor (please specify) _____

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:
(i) **X** the State
(ii) ___ State contractor (please specify):_____
(ii) **X** the ACOs

C. Enrollment and Disenrollment

1. Assurances.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements**. Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

2. Details.

Please describe the State's enrollment process for ACO selective contracting provider by checking the applicable items below.

a. Outreach.

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

special efforts made to reach and provide information to special populations included in the waiver program:

State's Response: The State provides outreach workers in all community health centers, most hospitals, local health departments, and state offices responsible for Aging and Adult Services and for Services for People with Disabilities. These locations all provide full services related to Medicaid eligibility. Effective July 1, 2007 outreach workers instruct enrollees to contact Medicaid Health Program Representatives to receive information and to select a health plan.

b. Administration of Enrollment Process.

X State staff conducts the enrollment process.

c. Enrollment.

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

X If a potential enrollee **does not select** an ACO within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. **X** Potential enrollees will have until the 15th of the current month or 10 days from the date of the State's letter informing the potential enrollee that he or she must choose a health plan (whichever is later) to choose a plan.

ii. **X** Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an ACO who is their current provider or who is capable of serving their particular needs.

State's response: After sufficient time has passed and attempts have failed for the potential enrollee to choose a health plan of his or her own choice, the Medicaid Health Program Representative (HPR) determines the best health plan match for each potential enrollee using the following process:

- The HPR reviews the potential enrollee's fee-for-service claims history to see if there is an established use of a provider's services. If the client has a clear history with a

particular physician, the HPR assigns the client to a health plan that includes the physician in its network.

- The HPR analyzes the client's TPL affiliations. If the client has TPL with a health plan that also has a Medicaid plan that uses the majority of the same providers, the client is assigned to that health plan.
- If the client has no apparent history with a particular physician, then the HPR will assign the client to the lowest cost ACO.
- If the HPR is aware that the client has special needs, the HPR makes extra efforts to reach the client by phone.

End of State's response.

X The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an ACO. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

State's Response: The exemption policy was developed to ensure individuals with special health care needs have access to appropriate health care. After the elimination of the primary care provider option in urban counties, there was concern that health plans may not be able to meet all of the medical needs of individuals with special health care problems. Even though such individuals have selected health plans since 1981, they had not done so in great numbers until it became mandatory in 1995 to choose a health plan.

The exemption process allows individuals who meet the exemption criteria to be exempted from choosing a health plan when the plan cannot immediately meet the needs of the client. Key points of the policy are that

-- the policy is sensitive to the diverse needs of individuals with special health care needs;
-- the process allows the health plans the opportunity to expand and strengthen their capacity to serve all Medicaid clients;
-- exemptions are made on an individual basis and only upon request; and
-- the policy does not create opportunities for systematic exclusions or inclusions of certain groups to financially benefit or harm any contracting health plan.

Exemption requests must be submitted for approval to the State's Health Plan Exemption Committee (HEC). Medicaid clients may request an exemption through an HPR, or by sending a request to the HEC or the Bureau of Managed Health Care's Director. The exemption may be approved if there is a reasonable expectation that the client's health would suffer if the client were unable to obtain an exemption.

It is not uncommon for Medicaid clients to ask a Medicaid Health Program Representative (HPR) if they can be exempt from having to choose a health plan. However, since July 1, 2005 there have been no formal exemption requests and the informal exemption requests have been successfully handled by the HPRs. In all cases, the informal exemption requests were denied not only because the reasons for the request did not meet criteria, but State staff resolved any issues by working with the health plans to resolve the clients' concerns.
End of State's response.

X The State **automatically re-enrolls** a beneficiary with the same ACO if there is a loss of Medicaid eligibility of 2 months or less.

Non-Traditional Medicaid Client Enrollment:

Beneficiaries covered under the Section 1115 Demonstration for the Primary Care Network of Utah will be required to enroll in a ACO (if living in an urban county) but their costs are excluded from the cost-effectiveness for this Section 1115 waiver.

d. Disenrollment:

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

X Enrollee submits request to State.

X The State has a **lock-in** period (i.e. requires continuous enrollment with ACO) of **up to12** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

State's response: In addition to the required good cause reasons, the State may request disenrollment during the lock-in period for the following reasons:

- Health plan no longer contracts with Medicaid
- Health plan no longer offers Medicaid in the enrollee's county
- Enrollee moves out of the health plan's service area
- Difficulty getting continuity of care with provider of choice
- Health plan not available when enrollee first enrolled with a health plan
- Enrollee has a third party insurance that matches a Medicaid health plan
- Enrollee becomes emancipated
- Enrollee is added to a different case
- Health plan cannot provide services to an enrollee with specific cultural/ethnic needs
- Health plan does not, because of moral or religious objections, cover the service the enrollee seeks

End of State's response.

X The State permits ACOs **to request disenrollment** of enrollees. Please check items below that apply:

i. **X** ACO can request reassignment of an enrollee for the following reasons:

State's Response: The health plan may initiate disenrollment of any enrollee based on one or more of the following reasons -

- If enrollee is abusive, threatening or acts violent
- If enrollee doesn't follow medical advice or doesn't keep a good relationship with his/her doctor/
- If enrollee allows someone else to use his/her Medicaid card
- If enrollee uses someone else's Medicaid card. The reasons must be specificially identified in the health plan's member handbook.

End of State's response.

ii. **X** The State reviews and approves all ACO initiated requests for enrollee transfers or disenrollments.

iii.**X** If the reassignment is approved, the ACO* notifies the enrollee in a direct and timely manner of the desire of the ACO to remove the enrollee from its membership.

State's clarification:
*The State's contracts with the ACOs will require it to notify the enrollee of the plan's decision to remove the enrollee from its membership.

iv. **X** The enrollee remains and enrollee of the ACO until another ACO is chosen or assigned.

D. Enrollee rights.

Assurances.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections**.** Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACO.

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

E. Grievance System

Assurances for All Programs.

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

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

Assurances For ACO programs.

ACOs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System**.** Further, the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACO.

Details for ACO programs.

a. Direct access to fair hearing.

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

b. Timeframes

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **30 calendar days** (between 20 and 90).

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

State's response: There is no timeframe required by the State.
End of State's response.

c. Special Needs

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

State's response: For clients who are hard of hearing, the State uses Utah Relay Services. For clients who are hard of hearing and speak Spanish, the State uses Spanish Relay Utah. The State has contracts with interpreters who speak or sign in all languages. **End of State's response.**

F. Program Integrity

1. Assurances.

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

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the ACO;
2. A person with beneficial ownership of five percent or more of the ACO equity;
3. A person with an employment, consulting or other arrangement with the ACO for the provision of items and services that are significant and material to the ACO's obligations under its contract with the State.

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

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

2. Assurances for ACO programs

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

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

X The CMS Regional Office will review and approve the ACO contracts for compliance with the provisions of section 1932(d)(1)

of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. Further, **the State assures that contracts complying with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the ACOs.**

G. Monitoring Plan and Results

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

ACO programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of ACO programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring

activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- ACO programs -- there must be at least one checkmark in each column.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication						ACO	ACO	ACO	ACO	ACO	ACO	ACO
Accreditation for Participation	ACO		ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO
Consumer Self-Report data						ACO	ACO	ACO	ACO	ACO	ACO	ACO
Data Analysis (non-claims)	ACO		ACO	ACO	ACO	ACO	ACO		ACO	ACO	ACO	ACO
Enrollee Hot lines			ACO			ACO	ACO	ACO	ACO	ACO		ACO
Focused Studies						ACO	ACO		ACO	ACO		ACO
Geographic mapping	ACO						ACO					
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups					ACO		ACO	ACO			ACO	ACO

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Network Adequacy Assurance by Plan		NA					ACO	ACO		ACO		
Ombudsman		NA					ACO	ACO	ACO	ACO		ACO
On-Site Review	ACO	NA	ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO	ACO
Performance Improvement Projects		NA					ACO		ACO			ACO
Performance Measures		NA					ACO	ACO		ACO		ACO
Periodic Comparison of # of Providers		NA						ACO				
Profile Utilization by Provider Caseload		NA										
Provider Self-Report Data		NA					ACO		ACO			
Test 24/7 PCP Availability		NA										
Utilization		NA							ACO	ACO		ACO

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Review												
		NA										
Other:		NA										
State Fair Hearings		NA				ACO				ACO		ACO

Details of Monitoring Activities and Results

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

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

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

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

X NCQA

X JCAHO

__ AAAHC

X Other (please describe) **State's description:** American Accreditation Healthcare Commission/URAC

Summary of results: Not applicable.

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

___ NCQA

___ JCAHO

___ AAAHC

_**X** Other (please describe)

State's response for ACOs: The State will require a ACO health plan to meet all of the relevant managed care regulations in 42 CFR 438-Managed Care. The ACOs must adhere to the requirements in the health plan contracts that are also integrated as Standards in the *QAPIP*. The State conducts periodic on-site reviews of the health plans to monitor the plans' compliance with all requirements using the *Utah Quality Assurance and Performance Improvement Plan* (*QAPIP*). In addition, in order to renew a contract authorized under this 1115 Waiver the ACOs will be required to participate in quality improvement activities specific to an ACO contract model as developed with input from providers and client advocates as orchestrated and coordinated by the Utah Department of Health..

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

X CAHPS (please identify which one(s))

__ State-developed survey

__ Disenrollment survey

__ Consumer/beneficiary focus groups

State's response: CAHPS surveys will continue to be conducted annually. The Medicaid agency contracts with the Utah Department of Health's Office of Health Care Statistics to oversee the survey process and publish the health plan performance reports. The surveys used are the CAHPS adult and children general population surveys. These surveys provide data in the areas of timely access, coordination of care, and quality of care.

The following questions reveal information about the areas noted:
Access
Questions related to access fall under the composite *Getting Care Quickly*.
There are additional questions specifically for child enrollees with chronic conditions including, *How much of a problem was it to get (medical equipment, special therapy, treatment or counseling)*?
Coordination/Continuity
Questions related to coordination/continuity fall under the composite *Getting Needed Care*.
There are additional questions specifically for child enrollees with chronic conditions including, *Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?* and, *Did anyone from you child's health plan, doctor's office of clinic help coordinate your child's care among different providers or services*"
Quality of Care
Questions related to quality of care fall are three questions on ratings (*Rating of Health Care*, *Rating of Personal Physician*, and *Rating of Specialist*).

The *2010 Performance Report for Utah Commercial HMOS and Medicaid & CHIP Health Plans* can be viewed by clicking on the following:
http://health.utah.gov/myhealthcare/reports/hedis/index.php
End State Response

Section III Reimbursement and Expenditures

This section describes how the Accountable Care Organizations (ACOs) will be paid under the 1115 demonstration waiver. The ACO reimbursement methodology is intended to accomplish two major objectives:

1. "[R]estructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the proposal, maintain or improve recipient health status."[1]

2. "[L]imit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs, when the rate of growth in the General Fund expenditures for all other programs is greater than zero."[2]

Traditional fee-for-service reimbursement occurs in a retrospective environment. This means that services have been rendered prior to provider claims being paid. In the ACO plan expenditures will be made to the organization responsible for the Utah Medicaid recipient's care, in advance of providing any services, through a capitated premium payment.

Prospective rate setting for the ACOs will be based more on the morbidity or health status of the clients served rather than on the specific services rendered. This concept is important as the model focuses more on quality outcomes for clients than that of counting specific costs of individual services rendered. Initially, the rates will target the current Medicaid spending applicable to the Medicaid clients in the ACO demographic area. Ongoing, the capitated per member per month (PMPM) rate will be tied to growth in the General Fund expenditures in the state, rather than to increases or decreases in the specific cost of providing quality, covered health services to the recipients enrolled in the ACO's program.

Upon enrollment with Medicaid, or at the annual plan selection period, recipients must decide: (1) if they want to choose the premium subsidy program or (2) if they want to enroll with an ACO. The premium subsidy program allows persons that are working, and have a premium requirement to receive insurance through their employer, to obtain healthcare through their employer. Medicaid would subsidize these premium payments and the recipients would receive their healthcare through the health plan provided by the employer. Under this selection, Utah Medicaid will make the monthly premiums directly to the employer's health insurance company.

On the other hand, if a Medicaid recipient chooses the ACO option, they would be required to also select an ACO.

[1] Utah Code 26-18-405(2)(a)
[2] Utah Code 26-18-405(2)(e)

A. Program Expenditures

Utah Medicaid expenditures have been increasing at a disproportionate rate when compared to other State expenditures. While Medicaid is a unique entitlement health care program having various federal rules and regulations, much of the increased costs are due to conditions prevailing in the health care industry as a whole. In an effort to preserve the long-term viability of the program, reduce the rate of increasing expenditures, and not only maintain but enhance quality, implementation of this waiver request would better align financial incentives in the health care system.

B. Reimbursement and Payment Strategy

Under the Utah Medicaid ACO model, ACO organizations will be paid a monthly premium for each Medicaid recipient enrolled in their plan. The premium amount will be established through actuarial certification based upon a person's eligibility category and a plan's historical risk experience. Medicaid eligibility categories and risk assignment will be explained in detail in the sections that follow.

ACO organizations are encouraged to use their premium payments to pay providers so as to create incentives for cost savings and foster innovations in care and quality outcomes across their provider networks. Medicaid does not prescribe the way each ACO would create such incentives. Individual plans are encouraged to be innovative and creative in their approach to care and coordination of care. As explained in other parts of this waiver document, the contract between Utah Medicaid and the ACOs is based upon quality outcomes rather than utilization of services. Since individual ACO plans must meet certain credentialing standards, Medicaid is assured that the care delivered will be calculated to achieve its purpose.

Included in the ACO model is cost sharing based upon sliding fee schedules which create incentives to save costs, promote innovation in the delivery of care, and enhance patient compliance with prescribed treatment. (Please refer to the copay schedule contained in the "Copayment for Accountable Care Organization Clients" section.)

1. Payment Stratified by Eligibility Group (Rate Cells)

The current major Medicaid eligibility groupings will continue in the ACO waiver. These categories are based upon criteria set by the federal government. Examples of some of the mandatory Medicaid eligibility groups include the following:

- *Limited income families with children (Temporary Aid for Needy Families or TANF).*
- Supplemental Security Income (SSI) recipients (aged, blind, and disabled)
- Infants born to Medicaid-eligible pregnant women.
- Children under age 6 and pregnant women whose family income is at or below 133% of the Federal poverty level.
- Recipients of adoption assistance and foster care
- Certain people with Medicare; and

- Special protected groups who may keep Medicaid for a period of time after the expiration of regular eligibility.

In general, the patterns of health resources consumed by distinct eligibility categories differ enough to warrant different premium amounts for their care. Accordingly, these groupings of eligibility types use health care resources at different levels due to differing age and health requirements (e.g., healthy babies use different physical resources for their care than would a disabled adult). Further, historical capitation payments have been paid by refined eligibility categories known as rate cells. The current rate cells are as follows:

Rate Cell
Traditional
A – Male (1-18 & 19-20 IL)
C – Female (1-18 & 19-20 IL)
E – Aged (65 years and older)
F – Technology Dependant Waiver
G – Disabled Male (all ages)
H – Disabled Female (all ages)
I – Medically Needy Child (0-18)
J – Medically Needy Adult (19-64 years)
K – Male (birth to 1 year)
L – Female (birth to 1 year)
N – Breast/Cervical Cancer (all ages)
P – Pregnant Woman (all ages)
R – Restriction (all ages)
Non-Traditional
B - Non-Traditional Male (19-64 years)
D - Non-Traditional Female (19-64 years)
Q - Non-Traditional Restrictions

Rates will include the cost to provide physical health services and their related prescription medications. This will align the financial incentive to providing excellent care outcomes.

Excluded Services:

- Psychotropic drugs (these will continue to be paid under fee-for-service)
- Mental health services (these will continue to be provided under the pre-paid mental health plan (PMHP) waiver)
- Dental services
- Long-term care services

2. Actuarial Certification

The rate setting for ACOs uses a risk based model. A PMPM premium is paid to each plan for each enrolled Medicaid recipient based upon the recipients' rate cells. Premium payments to the ACO are, by design, a risk based agreement that the ACO will provide all necessary care to the Medicaid clients to ensure appropriate, quality outcomes. There is no hold harmless or guaranteed break even.

The Centers for Medicare and Medicaid Services (CMS) requires actuarial certification of the premiums used in any risk program payments. This certification serves as an official acknowledgment from a credentialed actuary that the rates have been developed after analyzing historical data according to actuarial principles and practices. The rates represent what a health plan should be paid to cover the costs to provide defined health services. Actuarial soundness ensures that ACOs serving state Medicaid programs are adequately reimbursed for the cost of health care and the populations served. Actuarial soundness is a quality that is fair and adequate based on several defined criteria. It is an important tool for retaining the viability of ACOs as legitimate alternatives to Medicaid fee-for-service delivery systems.

The actuarial certification means a written statement by a member of the American Academy of Actuaries that the ACO health plan rates are in compliance with 42 CFR 438.6(c). Further, the certification is based upon the actuary's examination of the applicable health benefit plans. This includes a review of the appropriate records and of the actuarial assumptions and methods used by Medicaid in establishing premium rates. *(The actuarial checklist is included at the end of the section)*

One aspect of the rate structure includes development of risk factors for the ACO. This is a different risk issue from that of the ACO being *at risk.* The risk factors relate to examining the types of diagnoses patients receive. Based upon statistical analysis, persons with certain types of illnesses are likely to require more health care services. For example, a person with diabetes is more likely to go to the doctor multiple times during a year than another person who does not have diabetes. When comparing different ACO populations, actuarial risk adjustments are made to their rates to account for variances in the likelihood the population has of seeking care based upon their medical conditions.

C. Retain Supplemental Payments

Utah Medicaid provides several different supplemental payments to eligible Medicaid providers. Each of the supplemental payments has a different purpose and objective. The current supplemental payment categories are as follows:

- Disproportionate share hospital (DSH)
- Graduate Medical Education (GME)
- Inpatient Upper Payment Limit (UPL)
    - State government owned facilities
    - Privately owned facilities – These payments are funded through the Hospital Provider Assessment Act.

- Outpatient UPL
    - State government owned facilities
    - Non-State government owned facilities
- University of Utah Medical Group (UUMG)

These supplemental payments are currently allowed through the Utah Medicaid State Plan governing fee-for-service claims and are paid to providers in lump sum amounts. Guiding principles regarding these supplemental payments are:

1. DSH and GME supplemental payments will not be included in the ACO capitated rate calculation and will continue to be paid through fee-for-service.

2. Utah Medicaid will calculate the portion that each supplemental program will represents in each ACO's capitated rate.

3. Increased payments, via supplemental payment enhancement to the ACO rate, will result in a commensurate decrease in the fee-for-service supplemental payments.

4. Any non-federal matching dollars provided by government owned providers shall be paid to Medicaid.

5. The State will share the history of the supplemental payments made to qualifying providers with the ACO.

6. The State may not include anything in its contract with the ACO that directs dollars, other than GME if included, to be spent in any specific way.

1. Inpatient Upper Payment Limit

Supplemental payments equal to the Upper Payment Limit represent compensation for a hospital's total costs (allowed under federal regulation). These payments apply to two groups of hospitals: (1) state government owned and (2) private (non-government) owned hospitals.

Under the ACO waiver, Medicaid would estimate the specific UPL amounts based upon historical cost information. Qualifying UPL amounts would be included in the capitated ACO rates based upon which UPL providers are in each ACO network.

The non-federal share funding of these payments would be as follows:

State government owned hospitals – An intergovernmental transfer[3] (IGT) for the required non-federal share will be made to the Department for the portion of the ACOs capitated rate that is attributable to this specific supplemental payment based on the member months paid.

Private (non-government) owned hospitals – Utah Medicaid currently has a hospital provider assessment for private hospitals which funds the non-federal share of supplemental payments up to the inpatient upper payment limit. This legislation, known as the Hospital Provider Assessment Act is currently set to expire on June 30, 2013. This provider assessment is calculated based on total facility fee-for-service discharges.

The Hospital Provider Assessment Act will need to be amended to allow for a different methodology as the number of fee-for-service discharges will be reduced as a result of Medicaid clients enrolling in ACOs.

2. Outpatient Upper Payment Limit

This represents a separate UPL calculation for only outpatient hospital services. These payments apply to two groups of hospitals: (1) state government owned and (2) non-state government owned hospitals (seven facilities in rural areas of the state). The non-federal share of these payments is provided by these facilities through an IGT of funds prior to the payments being made.

Once the state converts to a reimbursement methodology for outpatient hospital services to a methodology that mimics Medicare, there may no longer be a UPL gap. A State Plan amendment will be required for the change in the fee-for-service reimbursement methodology. That amendment will request approval for supplemental outpatient UPL payments based upon a cost-to-charge methodology. If approved, a similar supplemental payment will be included in the ACO capitated rate.

3. University of Utah Medical Group

The University of Utah Medical Group (UUMG) receives supplemental payments based upon the variance between what they receive from Medicaid reimbursement and the average commercial rate. These payments are based upon FFS patient volumes. The UUMG, as part of the state teaching hospital, has the ability to provide the non-federal share for these supplemental payments through an IGT.

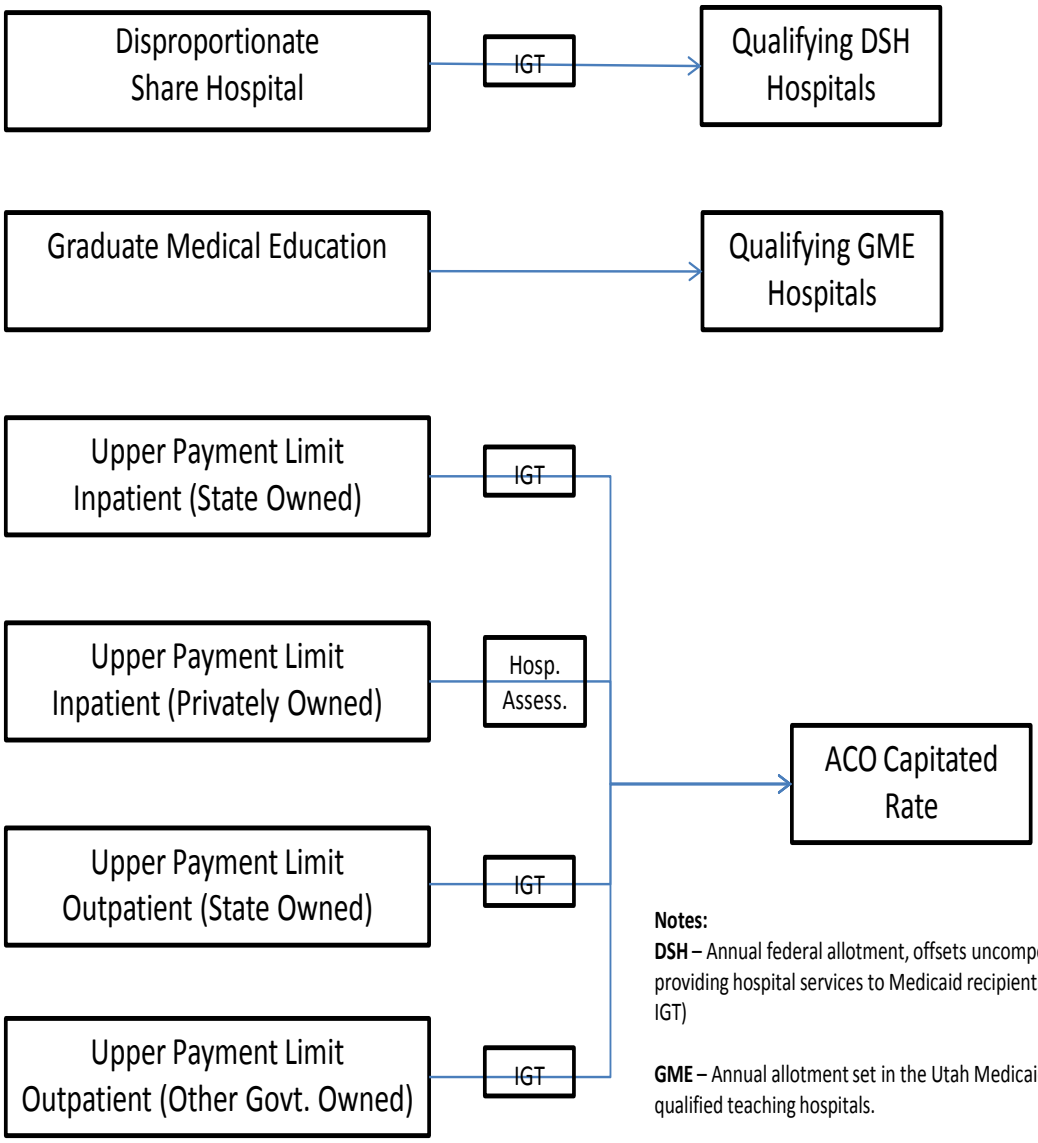
Premium rates to ACOs that have the UUMG on their provider panel would be adjusted based upon estimated volumes to UUMG physicians and the average commercial rate.

[3] Intergovernmental Transfers are payments between governmental entities. In the case of the supplemental payments outlined in this section, IGTs are dollars from the qualifying governmental hospitals for the non-federal share of the supplemental payments.

4. Funding Schematic

For a visual concept of the funding schematic, please see the chart on the next page.

Supplemental Payments Summary



Notes:

DSH – Annual federal allotment, offsets uncompensated care costs of providing hospital services to Medicaid recipients and the uninsured. (Some IGT)

GME – Annual allotment set in the Utah Medicaid State Plan, allocated to qualified teaching hospitals.

UPL – This amount represent the difference between Medicaid and Medicare reimbursement based upon guidelines established by CMS.

CMS Actuarial Checklist

CMS Medicaid Managed Care
Rate Setting Checklist

Item #	Legal Cite	Subject
AA.1.0	42 CFR 438. 6(c)(2)(i) and (ii) 42 CFR 438.806 SMM 2089.2, SMM 2092.8 SMM 2089.1	Overview of ratesetting methodology - The Contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms: Specifically, the contract includes: __ The rates and the time period for the rates, __ The risk-sharing mechanisms, __ The actuarial basis for the computation of those rates and risk-sharing mechanisms (*a lay person's description of the general steps the State followed to set rates is sufficient).* *Rate Development or Update* __ *The State is developing a new rate (RO completes steps AA.1 - AA.7).* __ *The State is adjusting rates approved under 42 CFR 438.6(c)-(RO completes all of step AA.1)*
AA.1.1	42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(2)(i) and (ii) 42 CFR 438.6(c)(3) 42 CFR 438.6(c)(4)(i) SMM 2089.2	Actuarial certification -The State must provide the actuarial certification of the capitation rates and payments under the contract. All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered, and the services to be furnished under the contract; and the Actuary must submit a certification, as meeting the requirements of the regulation, by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board. *Note: An Actuary who is a member of the American Academy of Actuaries will sign his name followed by the designation M.A.A.A., meaning a Member of the American Academy of Actuaries. For further information see* www.actuary.org/faqs.htm *Note: Actuaries can create either rates or rate ranges so long as the methodology (including all assumptions) to get to the actual rates in the contract are specified and meet CMS requirements. If there are instances where actuaries believe that information their State is required to submit would represent trade secrets or proprietary information, as described in the Freedom of Information Act (FOIA) (5 U.S.C. 552(a)), the information should be identified as such and may be withheld from public disclosure under the provisions of the FOIA.*
AA.1.2	42 CFR 438.6(c)(4)(iii)	Projection of expenditures -The State must provide a projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.
AA.1.3	45 CFR 74.43 and Appendix A 42 CFR 438.6(a)	Procurement, Prior Approval and Ratesetting - All contracts must meet the procurement requirements in 45 CFR Part 74. Regardless of the procurement method, the final rates must be in the contract and include documentation and a description of how the resulting contract rates are determined in sufficient detail to address this set of regulatory criteria for each contract. In general, there are

Item #	Legal Cite	Subject
	42 CFR 438.806(a) and (b)	two options: ___ Option 1: State set rates -- The rates are developed using a set of assumptions meeting federal regulations that results in a set of rates. Open cooperative contracting occurs when the State signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. Sole source contracting occurs where the state contracts with a single entity to provide a set of services must be documented as meeting the requirements of 42 CFR 438.6(c) under this option. ___ Option 2: Competitive Procurement -- The rates are developed using a set of assumptions meeting federal regulations that results in a range of acceptable bids to determine a bid range for rates. Competitive procurement occurs when entities submit bids and the State negotiates rates within the range of acceptable bids. *A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount.*
AA.1.5	42 CFR 447.15 42 CFR 438.2 42 CFR 438.812(a)	Risk contracts – The entity assumes risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceed the payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions including incentive payments are medical assistance costs.
AA.1.6	42 CFR 438.60	Limit on payment to other providers - The State agency must ensure that no payment is made to a provider other than the entity for services available under the contract between the State and the entity, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract to make payments for graduate medical education. *Note:* s*ee Step AA.3.8 for GME adjustments.*

Item #	Legal Cite	Subject
AA.1.7	42 CFR 438.6(c)(4)(i) and (ii) 42 CFR 438.6(c)(2)(i) and (ii) 42 CFR 438.6(c)(1)(i)(A) and (C) 42 CFR 438.6(c)(3) 42 CFR 438.6(c)(4)(ii)(A) 42 CFR 438.6(c)(1)(B) 42 CFR 438.6(c)(3)(ii) and (iv) SMM 2089.5	<u>Rate Modifications</u> - *This section is for use if the State updates or amends rates set under the new regulation at 42 CFR 438.6(c)*. The State has made program and rate changes that have affected the cost and utilization under the contract. The value and effect of these programmatic service changes on the rates should be documented. Adjustments for changes in the program structure or to reflect Medical trend inflation are made. Documentation meeting the requirements in step AA.3.0 – AA.3.24 is submitted to the RO for new adjustments. The adjustments include but are not limited to: • Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc). All trend factors and assumptions are explained and documented. See Step AA.3.9. • Programmatic changes include additions and deletions to the contractor's benefit package, changes in the eligible population, or other programmatic changes in the managed care program (or FFS program that affected the managed care program) made after the last set of rates were set and outlined in the regulation. The State may adjust for those changes if the adjustment is made only once (e.g., if the State projected the effect of a change in the last rate setting, then they must back out that projection before applying an adjustment for the actual policy effect) CMS allows rate changes (regardless of whether they are reductions or augmentations) and provides FFP in such changes as long as the changes are implemented through either a formal contract amendment or a multi-period contract and continue to meet all applicable statute provisions and regulations. If rate changes are implemented through a contract amendment, the amendment must receive approval by the RO before FFP in any higher payment amounts may be awarded. If the rate change is an anticipated development in a multi-year process, it must also be reviewed by the RO, consistent with guidelines for multi-year contracts. *If the amended rates use new actuarial techniques or different utilization data bases than was used and approved previously, the regional office should complete the entire checklist. Rates approved prior to the release of 42 CFR 438.6 must comply with the regulation by the period specified in the Federal Register.*
AA.2.0	42 CFR 438.6(c)(3)(i) and (iv) 42 CFR 438.6(c)(1)(i)(B)	<u>Base Year Utilization and Cost Data</u> - The State must provide documentation and an assurance that all payment rates are: • based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration) • Provided under the contract to Medicaid -eligible individuals. *In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.

Item #	Legal Cite	Subject
		Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the have the highest degree of reliability, subject to RO approval. *Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, and low-income health insurance program databases. Note: Some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could use the cost and utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.* *Note: The CMS RO may approve other sources not listed here based upon the reasonableness of the given data source. The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services.* Utilization data is appropriate to the Medicaid population and the base data was reviewed by the State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates. Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs. *Note: except in the case of payments to FQHCs that subcontract with entities, which are governed by section 1903(m)(2)(A)(ix), CMS does not regulate the payment rates between entities and subcontracting providers. Payment rates are adequate to the extent that the capitated entity has documented the adequacy of its network.* *The term "appropriate" means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services to be covered means that the rates must be based upon the State plan services to be provided under the contract. There is no stated or implied requirement that entities be reimbursed the full cost of care at*

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		billed charges.
AA.2.1	42 CFR 438.6(c)(1)(i)(B) 42 CFR 438.6(c)(4)(ii)(B)	Medicaid Eligibles under the Contract – All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates are appropriate for the populations to be covered and provided under the contract to Medicaid -eligible individuals. *The State may either include only data for eligible individuals and exclude data for individuals in the base period who would not be eligible for managed care contract services or apply an appropriate adjustment factor to the data to remove ineligibles if sufficient documentation exists. The explanation and documentation should list the eligibility categories specifically included and excluded from the analysis.* *Note: for example, if mentally retarded individuals are not in the managed care program, utilization, eligibility and cost data for mentally retarded eligibles should all be excluded from the rates.* *Note: all references in this checklist to Medicaid eligibles include 1115 expansion populations approved under 1115 demonstration projects.*
AA.2.2	1905(p) (1-3) SMM 3490 (ff) SMD letter 9/30/00	Dual Eligibles (DE)–Some States include capitation payments for DE. Because the statute and CMS policy specifies that the State may only pay for Medicaid-eligible individuals, those Medicaid payment limits must be observed if the program includes DE. See the Attachment to Appendix A for additional information on Dual Eligibles. Only the following groups of DE are entitled to Medicaid Services. If they are included in a capitated managed care contract, they should have a Medicaid rate calculated separately from other DE: ■ QMB Plus ■ Medicaid (Non QMB and Non SLMB) ■ SLMB Plus Eligibles and services for beneficiaries in the four non-Medicaid DE categories ■ QMB-only ■ QDWI ■ SLMB-only ■ QI-1 should be specifically excluded from the capitated rates calculated for the 3 DE categories above (QMB Plus, Medicaid (Non QMB and Non-SLMB), and SLMB Plus). If DE beneficiaries in the non-Medicaid four categories are allowed to choose to enroll in capitated managed care, the Medicaid State Agency would continue to be liable for the same Medicare payments (e.g., Medicare fee-for-service premiums) as under FFS. The beneficiary would be liable for any Medicaid services payment because they are not eligible for Medicaid services: For QMB-only and QMB-Plus, the State may also need to calculate a separate payment to the capitated organization for Medicare cost-sharing or premium amounts. If the M+C organization charges monthly premiums,. Medicaid is liable for payment of monthly M+C premium amounts for QMB categories (QMB-only and QMB Plus) for the basic packages of Medicare covered benefits only, if so elected in the Medicaid State plan (State Plan preprint page 29, 3.2(a)(1)(i)).

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		Medicaid is also liable for Medicare cost-sharing expenses (deductibles, coinsurance and copayments) for Medicare covered services to the payment amount specified in the Medicaid State plan (Supplement 1 to Attachment 4.19-B). When an M+C organization imposes cost-sharing charges in addition to premiums for Medicare-covered services on their enrollees, the Medicaid agency must pay those costs for QMBs regardless of whether the State elected to include premiums in cost-sharing. No Medicaid services or payments would be included in the payment calculated for the entity.
AA.2.3	42 CFR 435.1002(b) 1903(f)(2)(A) SMM 3645	Spenddown – FFP is not available for expenses that are the recipient's liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income. Spenddown is the amount of money that an individual with income over Medicaid eligibility limits must spend on medical expenses prior to gaining Medicaid eligibility. The spenddown amount is equal to the dollar amount the individual's income is over the Medicaid income limit. 42 CFR 435 Subpart D. States have two methods for calculating spenddown. Regardless of the option selected by the State, the State should not request federal Medicaid match for expenses that are the recipient's libility. Typically this means that capitated rates must be calculated without including expenses that are the recipient's liability. 1. Regular method – The individual client collects documentation verifying that a medical expense has occurred and submits to the State. States must ensure that capitation rates for individuals with spenddown (both medically needy beneficiaries and beneficiaries in 209(b) States with spenddown amounts) are calculated without including expenses that are the recipient's liability. 2. Pay-in method – The individual client pays a monthly installment payment or lump sum payment to the State equal to the spenddown amount rather than collecting documentation on medical expenses and submitting that documentation to the case worker. The same income and resource standards apply as in the regular method. The State then tracks the client's medical costs to ensure that the costs exceed the spendown amount. Here the State sets capitation rates to include expenses that are of the recipient's liability and must ensure that the federal government receives its share of the monthly or lump sum payment from the client.
AA.2.4	42 CFR 438.6(c)(1)(i)(B) 42 CFR 438.6(c)(4)(ii)(A)	State Plan Services only - The State must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration). *The explanation and documentation should list the services specifically included and excluded from the analysis.* Services provided by the managed care plan that exceed the services covered in the Medicaid State Plan may not be used to set capitated Medicaid managed care rates (e.g., 1915(b)(3) waiver services or services outlined in 42 CFR 438.6(e) as referenced in AA 2.5. • *States using entity **encounter data** may base utilization and service costs on non-FFS data adjusting the data to reflect State plan services only.*

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		• ***Services not part of the State plan*** *that are unilaterally contractually required or "suggested" (typically authorized as "1915(b)(3) services") may not be used to calculate actuarially sound rates and must be paid out of separate payment rates approved prospectively under the 1915(b) waiver process.* • ***EPSDT extended/supplemental services*** *for children are State Plan Approved services and may be built into the capitated rates* • ***1115(a)(2)*** *services are considered State Plan services for 1115 populations for the duration of the demonstration and may be built into capitated payments approved through the 1115 demonstration budget neutrality agreement for approved populations only.* • ***HCBS waiver services*** *may only be included for capitated contracts under 1915(b)/(c) concurrent waiver or in CMS RO approved 1915(a)(1)(A)/(c) capitated contracts for approved 1915(c) waiver participants. Note: for the purposes of pre-PACE under 1915(a)(1)(A) HCBS services should be included. If the population is a nursing home-certifiable population and eligible for HCBS, the State may consider HCBS as an acceptable service for long-term care managed care.* • ***1915(a)(1)(A) capitated rates*** *must be based on State Plan Approved services only and 1915(c) approved services for 1915(c) participants.* *Note: The inclusion of any additional Medicaid services during the term of a contract could either be handled through a contract amendment or a contract term that provides for the contingency, subject to CMS approval. Amendments must be prior approved by the CMS RO.*
AA.2.5	438.6(e)	<u>Services that may be covered by a capitated entity out of contract savings</u> - An entity may provide services to enrollees that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates. *Note: this is different than 1915(b)(3) waiver services which are contractually required by the State. When a State agency decides to contract with an entity, it is arranging to have some or all of its State plan services provided to its Medicaid population through that entity. The State has not modified the services that are covered under its State plan, nor is it continuing to pay, on a FFS basis, for each and every service to be provided by the entity. Further, entities have the ability to provide services that are in the place of, or in addition to, the services covered under the State plan, in the most efficient manner that meets the needs of the individual enrollee. These additional or alternative services do not affect the capitation rate paid to the entity by the State. The capitation rates should not be developed on the basis of these services. The State determines the scope of State plan benefits to be covered under the managed care contract, and sets payment rates based on those services. This does not affect the entities right, however, to use these payments to provide alternative services to enrollees that would not be available under the State plan to beneficiaries not enrolled in the entity.Section 1915(b)(3) waiver authority that allows a State to share savings resulting from the use of more cost-effective medical care with beneficiaries by providing them with additional services.*
AA.3.0	42 CFR	<u>Adjustments to the Base Year Data -</u> The State made adjustments to the

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	438.6(c)(3)(ii) and (iv)	base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population. All regulatorily referenced adjustments are listed in 3.1 through 3.14. Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment. Sample Adjustments to the Base Year that may increase the Base Year: • Administration (Step AA.3.2) • Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut (Step AA.3.1) • Claims completion factors (Step AA.3.2) • Medical service cost trend inflation (Step AA.3.3) • Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is taken into account (Step AA.3.11) • Certified Match provided by public providers in FFS • Cost-sharing in FFS is not in the managed care program • FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account • One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental) • Patient liability for institutional care will be charged under this program • Payments not processed through the MMIS • Price increase in FFS made after the claims data tape was cut Sample Adjustments to the Base Year that may adjust the Base Year downward: • Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1) • Cost-sharing in managed care in excess of FFS cost-sharing • Disproportionate Share Hospital Payments (Step AA.3.5) • Financial Experience Adjustment • FQHC/RHC payments • Graduate Medical Education (Step AA.3.8) • Income Investment Factor • Indirect Medical Education Payments (Step AA.3.8) • Managed Care Adjustment • PCCM Case Management Fee • Pharmacy Rebates • Post-pay recoveries (TPL) if the State will not collect and allow the MCE to keep TPL payments (Step AA.3.6) • Recoupments not processed through the MMIS • Retrospective Eligibility costs (Step AA.3.4) Cost-neutral Adjustments:

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		• Data smoothing for data distortions and individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims including risk-sharing and reinsurance (Step AA.5.0) *Note: The CMS RO must review all changes for appropriateness to the data selected by the State (e.g., if the State is using encounter data, then adjustments for FFS changes may not be appropriate). Some adjustments are mandatory. They are noted as such.* ***All adjustments must be documented. Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.***
AA.3.1	42 CFR 438.6(c)(1)(B) 42 CFR 438.6(c)(4)(ii)(A)	Benefit Differences - Actuarially sound capitation rates are appropriate for the services to be furnished under the contract. The State must document that actuarially sound capitation rates payments are based only upon services covered under the State Plan. *Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required for this adjustment.*
AA.3.2	42 CFR 438.6(c)(4)(ii) (A) 42 CFR 438.6(c)(3)(ii) 42 CFR 438. 812 Family Planning FMAP 1903(a)(5) and 42 CFR 433.10(c)(1) Title XIX Financial Management Review Guide #20 Family Planning Services (See page 1 of this guide for a complete list of statutory and regulatory references) 7/3/01 SMD Letter Indian Health Service facility	Administrative cost allowance calculations - The State must document that an adjustment was made to the rate to account for MCO, PIHP or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates. *Documentation of assumptions and estimates is required.* In order to receive Federal reimbursement, administrative costs at the entity level are subject to all applicable Medicaid administrative claiming regulations and policies. Medicaid pays for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. The following examples are not all inclusive. • Public entities cannot build in administrative costs to pay for non-Medicaid administration or services such as education, prisons, or roads, bridges and stadiums using the administrative cost in capitated rates. • Administrative costs for State Plan approved services can only be claimed for services to be delivered to Medicaid beneficiaries under the contract (not for 1915(b)(3) services. Administration costs in contracts must be allocated to the appropriate programs (e.g. public health must pay for the administration of public health services to non-Medicaid eligibles). CMS provides FFP only for the administration of Medicaid services to Medicaid beneficiaries covered under the contract. • Regular Medicaid matching rules apply. See 42 CFR 438.812 which states that all payments under a risk contract are medical assistance costs (FMAP rate) and which requires an allocation for non-risk contracts between service costs and administrative costs. Separate administrative costs under the State Plan should not be placed under a capitated contract in order for the State to draw down the FMAP (50-80%) rate rather than the administrative rate

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	FMAP 1905(b) and 42 CFR 433.10(c)(2)	(50%). Examples of this include: survey and certification costs or other administrative costs not associated with the plan's provision of contractually-required covered State Plan services to Medicaid enrollees. Separate administrative contracts including this administration can be written for capitated entities that will be matched at 50% by the federal government. *Note: Family planning and Indian health services enhanced matching FMAP rates and rules do apply to family planning and Indian Health services in capitated contracts. For family planning, the State must document the portion of its rates that are family planning consistent with the CMS Title XIX Financial Management Review Guide #20 Family Planning Services, especially Exhibit A. Please refer to the 7/3/01 SMD letter regarding the need for timely filing of claims.* • Paperwork costs, such as time spent writing up case notes, associated with face-to-face contact with an eligible member is already included in the direct service cost and should not be built into the capitated rates again. Medicaid State agencies should also not pay separately for this administration. This occurs when an entity contracts with a public entity to provide services. The public entity provides the direct services and then bills the State Medicaid agency or the entity for administration associated with the direct services. Schools are providing the primary examples of this practice. This could also occur if an entity builds in additional administrative costs associated with direct service that have already been built into the direct service rates to providers. *Note: CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates.*
AA.3.3	42 CFR 438.6(c)(3)(ii)	Special populations' adjustments - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.
AA.3.4	42 CFR 438.6(c)(3)(ii) and (iv)	Eligibility Adjustments - The actuary analyzed the covered months in the base period to ensure that member months are parallel to the covered months for which the entities are taking risk. Adjustments are often needed to remove from the base period covered months -- and their associated claims – that are not representative of months that would be covered by an entity. For example, many newborns are retrospectively covered by FFS Medicaid at birth, and will not enroll in an entity (even in mandatory enrollment programs) until a few months after birth. Because the costs in the first months of life are very high, if retrospective eligibility periods are not removed from the base period the state could be substantially over-estimating entities' average PMPM costs in the under-1 age cohort. Similar issues exist with the mother's costs when the delivery is retrospectively covered by FFS Medicaid, and with retrospective eligibility periods in general.

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AA.3.5	1923(i) BBA 4721(d)	DSH Payments *[contracts signed after 7/1/97]* – DSH payments may not be included in capitation rates. The State must pay DSH directly to the DSH facility.
AA.3.6	42 CFR 433 Sub D 42 CFR 447.20 SMM 2089.7	Third Party Liability (TPL) – The contract must specify any activities the entity must perform related to third party liability. The Documentation must address third party liability payments and whether the State or the entity will retain TPL collections. Rates must reflect the appropriate adjustment (i.e., if the entity retains TPL collections the rates should be adjusted downward or if the State collects and retains the TPL the rates should include TPL).
AA.3.7	42 CFR 447.58 SMM 2089.8	Copayments, Coinsurance and Deductibles in capitated rates –If the State uses FFS as the base data to set rates and the State Medicaid agency chooses not to impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the State must calculate the capitated payments to the organization as if those cost sharing charges were collected. For example, if the State has a $2 copayment on FFS beneficiaries for each pharmacy prescription, but does not impose this copayment on any managed care member, the State must add back an amount to the capitated rates that would account for the lack of copayment. *Note: this would result in an addition to the capitated rates.* For 1115 expansion beneficiaries only, if the state usees FFS as the base data to set rates and imposes more deductibles, coinsurance, co-payments or similar charges on capitated members than the State imposes on its fee-for-service beneficiaries, the State must calculate the rates by reducing the capitation payments by the amount of the additional charges. *Note: this would result in a reduction to the capitated rates.*
AA.3.8	42 CFR 438.60 42 CFR 438.6(c)(5)(v)	Graduate Medical Education (GME) - If a State makes GME payments directly to providers, the capitation payments should be adjusted to account for the aggregate amount of GME payments to be made on behalf of enrollees under the contract (i.e., the State should not pay the entity for any GME payments made directly to providers). States must first establish actuarially sound capitation rates prior to making adjustments for GME. CMS permits such payments only to the extent the capitation rate has been adjusted to reflect the amount of the GME payment made directly to the hospital. States making payments to providers for GME costs under an approved State plan must adjust the actuarially sound capitation rates to account for the aggregate amount of GME payments to be made directly to hospitals on behalf of enrollees covered under the contract. These amounts cannot exceed the aggregate amount that would have been paid under the approved State plan for FFS. This prevents harm to teaching hospitals and ensures the fiscal accountability of these payments.
AA.3.9	1903(m)(2)(A)(ix) 1902(bb)	FQHC and RHC reimbursement – The State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs. The State may NOT include the FQHC/RHC encounter rate, cost-settlement, or prospective payment amounts. The entity must pay FQHCs and RHCs no less than it pays non FQHC and RHCs for similar services. In the absence of a specific 1115 waiver the entity cannot pay the annual cost-settlement or prospective payment.

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AA.3.10	42 CFR 438.6(c)(3)(ii)	Medical Cost/Trend Inflation – Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented. *Note: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.*
AA.3.11	42 CFR 438.6(c)(3)(ii) and (iv)	Utilization Adjustments - Generally, there are two types of Utilization adjustments are possible: utilization differences between base data and the Medicaid managed care population and changes in Medical utilization over time. • Base period differences between the underlying utilization of Medicaid FFS data and Medicaid managed care data assumptions are determined. These adjustments increase or decrease utilization to levels that have not been achieved in the base data, but are realistically attainable CMS program goals. States may pay for the amount, duration and scope of State plan services that States expect to be delivered under a managed care contract. Thus, States may adjust the capitation rate to cover services such as EPSDT or prenatal care at the rate the State wants the service to be delivered to the enrolled population. The RO should check to ensure that the State has a contract clause for using mechanisms such as financial penalties if service delivery targets are not met or incentives for when targets are met. *Note: an example of this adjustment is an adjustment to Medicaid FFS data for EPSDT where FFS beneficiaries have historically low EPSDT utilization rates and the managed care contract requires the entity to have a higher utilization rate. The State should have a mechanism to measure that the higher utilization occurs and the RO should verify that this measurement occurs.* • A change in utilization of medical procedures over time is taken into account. Documentation is required if this adjustment is made. The State should document 1) The assumptions made for the change in utilization. 2) How it came to the precise adjustment size. 3) That the adjustment is a unique change that could not be reflected in the utilization database because it occurred after the base year utilization data tape was cut. Examples may include: major technological advances (e.g., new high cost services) that cannot be predicted in base year data (protease inhibitors would be acceptable, a new type of aspirin would not be acceptable). *Note: These adjustments can be distinguished from each other. The first is utilization change stemming from historic under- or over-utilization that is being corrected solely by the implementation of this program. Historic access problems in FFS Medicaid programs may be addressed*

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		through this adjustment. The second is a one time only non-recurring adjustment because of a unique utilization change projected to occur (or which did occur) after the base year data tape was produced.
AA.3.12	42 CFR 438.6(c)(4)(ii) 42 CFR 438.6(c)(3)(iv) 42 CFR 438.6(c)(1)(i)(B)	Utilization and Cost Assumptions – The State must document that the utilization and cost data assumptions for a voluntary program were analyzed and adjusted to ensure that they are appropriate for the populations to be covered if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates are set). The State must document that utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing or other appropriate cost-neutral methods *Note: this analysis is needed whenever the population enrolled in the managed care program is different than the data for which the rates were set (e.g., beneficiaries have a choice between a fee-for-service program (PCCM) and a capitated program (MCO) and the rates are set using FFS data)* .
AA.3.13	42 CFR 435.725 (Categorically Needy) 42 CFR 435.832 (Medically Needy)	Post-Eligibility Treatment of Income (PETI) *(This applies for NF, HCBS, ICF-MR, and PACE beneficiaries in capitated programs where PETI applies only*.) If the State Plan or waiver requires that the State consider post-eligibility treatment of income for institutionalized beneficiaries, the actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The State should calculate the client participation amount specifically for each member using the FFS methodology. *Patient liability is a post-eligibility determination of the amount an institutionalized Medicaid beneficiary is liable for the cost of their care. It is also called client participation, cost of care, PE, and post-eligibility treatment of income. 42 CFR 435 Subpart H. Client participation should not be used to reduce total costs for all participants. Client participation should be assessed individually, reducing the individual rate paid to the capitated entity, not computed in aggregate and reducing all capitation payments. If the MMIS data tape is cut to reflect only the amount the Medicaid agency paid providers, then patient liability for cost of care must be added back to the rate to determine the total cost of care for an individual. The actual rate paid to the capitated entity would be the rate for the member minus any patient liability for that specific enrolled member. The capitated entity would then need to collect the patient liability from the enrolled member.* An Option under 42 CFR 435.725(f) - The State can use a projection of expenses for a prospective period not to exceed 6 months to calculate client participation. This option requires the State to reconcile estimates with incurred expenses. Even with this option, the State must reduce the capitation rate to exclude expenses that are of the recipient's liability. This procedure ensures that the federal government does not pay more that its share of costs.
AA.3.14	42 CFR 438.6(c)(3)(ii)	Incomplete Data Adjustment– 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 Actuary must calculate an estimate of the

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		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.*
AA.4.0	42 CFR 438.6(c)(3)(iii) FR 6/14/02 p41001	Establish Rate Category Groupings (All portions of subsection AA.4 are mandatory) -- The State has created rate cells specific to the enrolled population. *The rate category groupings were made to construct rates more predictable for future Medicaid populations' rate setting. The number of categories should relate to the contracting method. Rate cells need to be grouped together based upon predictability so entities do not have incentives to market and to enroll one group over another. Multiple rate cells should be used whenever the average costs of a group of beneficiaries greatly differ from another group and that group can be easily identified. Note: The State must document that similar cost categories are grouped together to improve predictability. For example, rate cells may be combined if there is an insufficient number of enrollees in any one category to have statistical validity.*
AA.4.1	42 CFR 438.6(c)(3)(iii)(B)	Age - Age Categories are defined. If not, justification for the predictability of the methodology used is given.
AA.4.2	42 CFR 438.6(c)(3)(iii)(C)	Gender -Gender Categories are defined. If not, justification for the predictability of the methodology used is given
AA.4.3	42 CFR 438.6(c)(3)(iii)(D)	Locality/Region - Locality/region Categories are defined. If not, justification for the predictability of the methodology used is given
AA.4.4	42 CFR 438.6(c)(3)(iii)(E)	Eligibility Categories - Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given.
AA.5.0	42 CFR 438.6(c)(3)(ii), (iii) and (iv) 42 CFR 438.6(c)(1)(ii)	Data Smoothing (All portions of subsection AA.5 are mandatory) - The State has examined the data for any distortions and adjusted in a cost-neutral manner for distortions and special populations. Distortions are primarily the result of small populations, special needs individuals, access problems in certain areas of the State, or extremely high-cost catastrophic claims. Costs in rate cells are adjusted through a cost-neutral process to reduce distortions across cells to compensate for distortions in costs, utilization, or the number of eligibles. This process adjusts rates toward the statewide average rate. The State must supply an explanation of the smoothing adjustment, an understanding of what was being accomplished by the adjustment, and demonstrate that, in total, the aggregate dollars accounted for among all the geographic areas after smoothing is basically the same as before the smoothing. The State has taken into account individuals with special health care needs and catastrophic claims. These populations should only be included if they are an eligible, covered population under the contract. Claim costs and utilization for high cost individuals (e. g., special needs children) in the managed care program are included in the rates.
AA.5.1	42 CFR 438.6(c)(3)(iv)	Special Populations and Assessment of the Data for Distortions – Because the rates are based on actual utilization in a population, the State must assess the degree to which a small number of catastrophic claims might be distorting the per capita costs. Other payment mechanisms and utilization and cost assumptions that are appropriate

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		for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing, or other appropriate cost-neutral methods may be necessary. If no distortions or outliers are detected by the actuary, a rate setting method that uses utilization and cost data for populations that include individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims will meet requirements for special populations without additional adjustments, since the higher costs would be reflected in the enrollees' utilization. States must document their examination of the data for outliers and smooth appropriately. The fact that the costs of these individuals are included in the aggregate data used for setting rates will not account for the costs to be incurred by a contractor that, due to adverse selection or other reasons, enrolls a disproportionately high number of these persons. CMS requires some mechanism to address this issue. Most entity contracts currently use either stop-loss, risk corridors, reinsurance, health status-based risk adjusters, or some combination of these cost-neutral approaches. *Note: The RO should verify that this assessment occurred and that distortions found were addressed in 5.2.*
AA.5.2	42 CFR 438.6(c)(1)(iii) 42 CFR 438.6(c)(3)(ii) and (iv) SMM 2089.6	Cost-neutral data smoothing adjustment -- If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques **must** be made. Cost neutral means that the mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments. Actuarially sound risk sharing methodologies will be cost neutral in that they will not merely add additional payments to the contractors' rates, but will have a negative impact on other rates, through offsets or reductions in capitation rates, so that there is no net aggregate assumed impact across all payments. A risk corridor model where the State and contractor share equal percentages of profits and losses beyond a threshold amount would be cost neutral. The mechanism should be cost neutral in the aggregate. How that is determined, however, will differ based on the type of mechanism that is used. A stop-loss mechanism will require an offset to capitation rates under the contract, based on the amount and type of the stop-loss. Health status-based risk adjustment may require an adjustment to the capitation rate for all individuals categorized through the risk adjustment system, but the aggregate program impact will still be neutral. CMS will recognize that any of these mechanisms may result in actual payments that are not cost neutral, in that there could be changes in the case mix or relative health status of the enrolled population. As long as the risk sharing or risk adjustment system is designed to be cost neutral, it would meet this requirement regardless of unforeseen outcomes such as these resulting in higher actual payments.

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		Data Smoothing Techniques: ___ Provision of stop loss, reinsurance, or risk-sharing (See 6.0) ___ Catastrophic Claims Adjustment – The State must identify that there are outlier cases and explain how the costs associated with those outlier cases were separated from the rate cells and then redistributed across capitation payment cells in a cost-neutral, yet predictive manner. ___ Small population or small rate cell adjustment – The State has used one of three methods: 1) The actuary has collapsed rate cells together because they are so small, 2) the actuary has calculated a statewide per member per month for each individual cell and multiplied regional cost factors to that statewide PMPM in a cost-neutral manner, or 3) the actuary bases rates on multiple years data for the affected population weighted so that the total costs do not exceed 100% of costs (e.g., 3 years data with most recent year's data weighted at 50%, 2nd most recent year's data weighted at 30% and least recent year weighted at 20%). ___ Mathematical smoothing – The actuary develops a mathematical formula looking at claims over a historical period (e.g., 3 to 5 years) that identifies outlier cost averages and corrects for skewed distributions in claims history. The smoothing should account for cost averages that are higher and lower than normal in order to maintain cost-neutrality. ___ Maternity Kick-Payment (Per delivery rate) – Non-delivery related claims were separated from delivery related claims. The non-delivery related claims were sorted into categories of service and used to base the managed care capitation payments. Delivery-related costs were removed from the total final paid claims calculations. The State developed a tabulation of per-delivery costs only. The State reviewed the data for accuracy and variance. The State develops a single, average, per-delivery maternity rate across all cohorts and across all regions unless variance warrants region-specific per-delivery maternity rates. Some states also have birth kick payments to cover costs for a newborn's birth (Per newborn rate). ___ Applying other cost-neutral actuarial techniques to reduce variability of rates and improve average predictability. If the State chooses to use a method other than the catastrophic claims adjustment or a small population or small rate cell adjustment, the State explains the methodology. The actuary assisted with the development of the methodology, the approach is reasonable, the methodology was discussed with the State, and an explanation and documentation is provided to CMS.
AA.5.3	42 CFR 438.6(c)(1)(iii) 42 CFR 438.6(c)(3)(iii) and (iv)	Risk Adjustment- The State may employ a risk adjustment methodology based upon enrollees health status or diagnosis to set its capitated rates. If the State uses a statistical methodology to calculate diagnosis based risk adjusters they should use generally accepted diagnosis groupers. The RO should verify that: • The State explains the risk assessment methodology chosen • Documents how payments will be adjusted to reflect the expected costs of the disabled population • Demonstrates how the particular methodology used is cost-

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		neutral • Outlines periodic monitoring and/or rebasing to ensure that the overall payment rates do not artificially increase, due to providers finding more creative ways to classify individuals with more severe diagnoses (also called upcoding or diagnosis creep). Risk-adjustment must be cost-neutral. *Note: for example, risk-adjustment cannot add costs to the managed care program. Risk adjustment can only distribute costs differently amongst contracting entities.*
AA.6.0	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) 42 CFR 438.6(c)(2)(ii)	<u>Stop Loss, Reinsurance, or Risk-sharing arrangements (8.0 is mandatory if the State chooses to offer one of these options)</u> *(State Optional Policy)* – The State must submit an explanation of state's reinsurance, stop loss, or other risk-sharing methodologies. These methodologies must be computed on an actuarially sound basis. *Note: If the State utilizes any of the three risk-sharing arrangements, please mark the applicable method in 8.1, 8.2, or 8.3. For most contracts, the three options are mutually exclusive and a State will use only one technique per contract. If a State or contract uses a combination of methodologies in a single contract, the State must document that the stop loss and risk-sharing do not cover the same services simultaneously. Plans are welcome to purchase reinsurance in addition to State-provided stop loss or risk-sharing, but CMS will not reimburse for any duplicative cost from such additional coverage.* The contract must specify any risk-sharing mechanisms, and the actuarial basis for computation of those mechanisms. *Note: In order for the mechanism to be approved in the contract, the State or its actuary will need to provide enough information for the reviewer to understand both the operation and the financing of the risk sharing mechanism.* Capitation rates are based upon the probability of a population costing a certain rate. Even if the entity's premium rates are sufficient to cover the probable average costs for the population to be served, the entity is always at risk for the improbable – two neonatal intensive care patients and one trauma victim in its first 100 members, or an extraordinarily high rate of deliveries. A new entity, with a small enrollment to spread the risk across, could be destroyed by one or two adverse occurrences if it were obliged to accept the full liability. FFP is not available to fund stop loss and risk-sharing arrangements on the provision of non-State Plan services.
AA.6.1	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i)	<u>Commercial Reinsurance</u> – The State requires entities to purchase commercial reinsurance. The State should demonstrate that the contractor has ensured that the coverage is adequate for the size and age of the entity.
AA.6.2	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i)	<u>Simple stop loss program</u> -- The State will provide stop-loss protection by writing into the contract limits on the entity's liability for costs incurred by an individual enrollee over the course of a year (either total costs or for a specific service such as inpatient care). Costs beyond the limits are either entirely or partially assumed by the State. The entity's

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	SMM 2089.6	capitation rates are reduced to reflect the fact that the State is assuming a portion of the risk for enrollees. ■ The State has included in its documentation to CMS the expected cost to the State of assuming the risk for the high cost individuals at the chosen stop-loss limit (also called stop-loss attachment point). ■ An explanation of the State's stop loss program includes the amount/percent of risk for which the State versus entity will be liable. ■ The State has explained liability for payment. In some contracts, the entity is liable up to a specified limit and partially liable for costs between that limit and some higher number. The State is wholly liable for charges above the higher limit. If there is shared risk rather than either the State or the entity entirely assuming the risk at a certain point, the entity and State determine whether the services will be reimbursed at Medicaid rates, at the entities' rates, or on some other basis. The State must specify which provider rates will be used to establish the total costs incurred so that the entity clearly knows whether the reinsurance will pay (i.e., the attachment point is reached). ■ The State has deducted a withhold equal to the actuarially expected cost to the State of assuming the risk for high cost individuals. The State pays out money based on actual claims that exceed the stop loss limit (i.e., above the attachment point). ■ The State has documented whether premiums will be developed by rate cell or on a more aggregated basis.
AA.6.3	42 CFR 438.6(c)(4)(iv) 42 CFR 438.6(c)(5)(i) and (ii) 42 CFR 438.6(c)(1)(v)	Risk corridor program – Risk corridor means a risk sharing mechanism in which States and entities share in both profits and losses under the contract, outside of a predetermined threshold amount, so that after an initial corridor in which the entity is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits. If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to the extent that they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished to enrolled individuals, plus an amount for entity administrative costs directly related to the provision of these services. The State agrees to share in both the aggregate profits and losses of an entity and protect the entity from aggregate medical costs in excess of some predetermined amount. To the extent that FFP is involved, CMS will also share in the profits and losses of the entity. In this instance, the State and CMS must first agree upon the benchmark point up to which federal match will be provided. Federal matching is available up to the cost of providing the same services under a non-risk contract (i.e., the services reimbursed on a Medicaid fee-for-service basis plus an amount for entity administrative costs related to the provision of those services). See 447.362. States typically require entities to adopt the Medicare cost-based entity principles for

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		the purposes of calculating administrative costs under this model. ***Note: For this example, let's say the payment is $100 and there are 10 members expected to enroll. The total capitated payment CMS will match is $1,000.*** - ***The State and the entity must then agree on the amount of risk to be shared between them (e.g., 5% or the risk corridor is between $950 and $1,050).*** - ***The entity must calculate its overall costs at the end of the year and submit them to the State.*** - ***Scenario 1, the entity costs are $950: In this example, the entity's profits are within the risk corridor of $950 to $1,050, so the entity keeps the entire amount of capitated payments and no adjustment is made.*** - ***Scenario 2, the entity costs are $1,050: In this example, the entity's loss is within the risk corridor, so the entity keeps the entire amount of the capitated payment and no adjustment is made.*** - ***Scenario 3, the entity costs are $850: In this example, the entity profit is outside of the risk corridor, so the entity must pay the State the amount of the excess profit or $100.*** - ***Scenario 4, the entity costs are $1,150: In this example, the entity loss is outside of the risk corridor, so the State must pay the entity the amount of the excess loss or $100.*** ***Please note: FFP is not available for amounts in this contract over the fee-for-service cost of providing these services. In order to compute the fee-for-service cost of providing services, the State must "price" the capitated entity's encounter data through the State's fee-for-service MMIS system. Amounts exceeding the cost of providing these services through a non-risk contract are not considered actuarially sound. The State must "price" the encounter data for entities with open ended risk-corridors (meaning there is no limit to the State's liability) when the entity exceeds the aggregate of actuarially sound rates x member months by more than 25%. In practice the RO may require the "pricing" of encounter data whenever evidence suggests that the non-risk threshold has been exceeded. Similarly, the State can require documentation if evidence suggests that the entity should be profit sharing below the threshold. In this example, if the fee-for-service and entity administrative cost of providing these services were $1,100, then FFP would only be available up to $1,100. See 42 CFR 447.362 or Step AA.1.8 of this checklist.***
AA.7.0	42 CFR 438.6(c)(4)(iv) 42 CFR	<u>Incentive Arrangements (9.0 is mandatory if the State chooses to implement an incentive)</u> *(State Optional Policy)* – Incentive arrangement means any payment mechanism under which an entity may receive additional funds over and above the capitation rates it was

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	438.6(c)(5)(iii) and (iv) SMM 2089.3 42 CFR 438.6(c)(2)(i) 42 CFR 438.6(c)(1)(iv) 42 CFR 438.6(c)(4)(ii)	paid for meeting targets specified in the contract. The State must include an explanation of the State's incentive program. Payments in contracts with incentives may not exceed 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such payments will not be considered actuarially sound. The State must document that any payments under the contract are actuarially sound, are appropriate for the populations covered and services to be furnished under the contract, and based only upon services covered under the State Plan to Medicaid-eligible individuals (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration). • All incentives must utilize an actuarially sound methodology and based upon the provision of approved services to Medicaid eligible beneficiaries. • Incentives cannot be renewed automatically and must be for a fixed time period. • The incentive cannot be conditioned upon intergovernmental transfer agreements. • Incentives must be available to both public and private contractors. *Note: Reinsurance collections from reinsurance purchased from a private vendor (See 8.1) and State provided stoploss (8.2) are actuarially calculated to be cost-neutral and should not considered to be "incentives" or included in these payments.*

Section IV Cost Neutrality

1. Limit on Title XIX Funding

The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

2. Risk

The State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of Medicaid eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

3. Calculation of the Budget Neutrality Limit

For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each demonstration year (DY) on a total computable basis, as described in #4 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the Demonstration period for the types of Medicaid expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in #5 below.

4. Demonstration Populations Used to Calculate the Budget Neutrality Limit

For each DY, separate annual budget limits of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State. The waiver assumes a 6.3% trend rate – the rate currently used for Utah's 1115 Primary Care Network Waiver. The base year for DY 1 is established by taking 2010 calendar year expenditures for each group and inflating them forward for a July 2012 start date (DY 1). The trend rates and per capita cost estimates for each Rate Cell for each year of the demonstration are listed in the table below.

Rate Cell	Description
A	Male (1-18 & 19-20 IL)
C	Female (1-18 & 19-20 IL)
E	Aged (65 years and older)
F	Technology Dependant Waiver
G	Disabled Male (all ages)
H	Disabled Female (all ages)
I	Medically Needy Child (0-18)
K	Male (birth to 1 year)
L	Female (birth to 1 year)
N	Breast/Cervical Cancer (all ages)
P	Pregnant Woman (all ages)
R	Restriction (all ages)

Rate Cell	Trend Rate	DY 1 (Base Year)	DY 2	DY 3	DY 4	DY 5
A	6.30%	$104.80	$111.40	$118.42	$125.88	$133.81
C	6.30%	$105.28	$111.92	$118.97	$126.46	$134.43
E	6.30%	$124.49	$132.33	$140.67	$149.53	$158.95
F	6.30%	$8,436.38	$8,967.87	$9,532.84	$10,133.41	$10,771.82
G	6.30%	$510.67	$542.84	$577.04	$613.40	$652.04
H	6.30%	$519.21	$551.92	$586.69	$623.65	$662.94
I	6.30%	$141.95	$150.90	$160.40	$170.51	$181.25
K	6.30%	$568.71	$604.54	$642.63	$683.11	$726.15
L	6.30%	$488.44	$519.21	$551.92	$586.69	$623.65
N	6.30%	$2,195.40	$2,333.71	$2,480.73	$2,637.02	$2,803.15
P	6.30%	$1,096.76	$1,165.86	$1,239.31	$1,317.39	$1,400.38
R	6.30%	$1,181.53	$1,255.97	$1,335.09	$1,419.20	$1,508.61

5. Composite Federal Share Ratio

The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

6. Exceeding Budget Neutrality

The budget neutrality limit calculated above in #3 will apply to actual expenditures for demonstration services as reported by the State. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

7. New Funding

If the State seeks to reallocate title XXI or Disproportionate Share Hospital funds to fund this demonstration, the State must request a demonstration amendment. These funds are only available on a prospective basis. In order to provide for a seamless continuation of 1115 waiver authority for the eligibles under title XIX, the State should provide CMS with adequate notification of the State's intent.

8. Enforcement of Budget Neutrality

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. In addition, no later than 6 months after the end of each DY, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, it must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+8.0 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+3.0 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+1.0 percent
DY 4	DYs 1 through 4 combined budget neutrality limit	+0.5 percent
DY 5	DYs 1 through 5 combined budget neutrality limit	0 percent

Section V Public Notice

A. Introduction and Background

The proposed federal regulations published on September 17, 2010 contain very specific public notice requirements. Each of those requirements will be addressed in the following narrative.

1. Contents of the Public Notice and Publishing

The waiver application notice was published on June 1, 2011 in the State Bulletin, which conforms to the Utah Administrative Procedures Act. The notice directed interested parties to the website where the application is available for review (http://health.utah.gov/medicaid/stplan/1115%20Waivers.htm). The public notice is shown below:

Request for Public Comments and Public Notice
for Accountable Care Organizations

We are pleased to invite comment regarding a new Accountable Care Organization Section 1115 Waiver demonstration initiative.

Utah will submit a draft waiver for review by the Centers for Medicare and Medicaid Services (CMS). The formal waiver request will be submitted after public comment is received.

In response to the recently passed Senate Bill 180, Medicaid Reform, the Utah Department of Health is submitting a Section 1115 Demonstration Waiver authorized by Title XIX of the Social Security Act. The waiver, if approved, will establish Accountable Care Organizations (ACO) in Utah, Salt Lake, Weber and Davis counties.

The waiver will allow the State to convert its current managed care contracts to an Accountable Care Organization model. The ACO model will better align financial incentives to control costs and to deliver appropriate care to clients. The model eliminates incentives to provide surplus care while at the same time maintaining and increasing the quality of service.

The reimbursement for ACO services will be through prospective rate setting based on the health status of individuals, while allowing flexibility in the delivery of appropriate care. This reimbursement structure customizes risk adjustment models that are consistent with historical expenditures of statewide averages modified by categories of risk.

To ensure the quality of care, each ACO will have a medical home component. This component will customize, coordinate and facilitate care. Further, the ACO must meet quality of care and access to care standards monitored by external, and nationally

recognized, professional entities whose entire focus is monitoring the quality of medical care services.

The Department of Health anticipates that there will be no decrease in the current level of Medicaid expenditures. Rather, the waiver is intended to reduce the rate of increase in future Medicaid appropriations.

The Department of Health is committed to an extensive public process. We want you to have an opportunity to see the waiver amendment, understand the concepts and offer your comments. The waiver application will be available for your review and comment on June 1, 2011 at http://health.utah.gov/medicaid/stplan/1115%20Waivers.htm. It will also be available at local health departments.

We will provide two public forums for comments. The first will be from 10:00 AM to 12:00 PM on June 7, 2011 at the Cannon Health Building, room #125, 288 North 1460 West, Salt Lake City, Utah 84116. The second will be during the Medical Care Advisory Committee meeting from 4:00 PM to 6:00 PM on June 9, 2011 at the Cannon Health Building, room #125, 288 North 1460 West, Salt Lake City, Utah 84116.

We invite your comments and questions by June 20, 2011. You may direct comments to the Utah Department of Health, Division of Medicaid and Health Financing, PO Box 143102, Salt Lake City, Utah 84114-3102.

The waiver application contained the information as applicable under Section II Provisions of the Proposed Rule, Section A(4) 1115 Demonstrations, State Public Notice Process.

2. Public Hearings

There were two public hearings. The first was on June 7, 2011 at the Cannon Health Building, conference room #125, 288 North 1460 West, Salt Lake City, Utah 84116 at 10:00 AM to Noon. The second public hearing was held during a special meeting of the Medicaid Care Advisory Committee. It was on June 9, 2011 at the Cannon Health Building in room #125 from 4:00 PM to 6:00 PM.

At both public hearings, and in the public notice, comments were invited and could be sent to Department of Health, Division of Medicaid and Health Financing, PO Box 1433102, Salt Lake City, Utah 84116-3102.

3. Community Workgroup

To assist in the preparation of the waiver application, a workgroup was formed to provide input, consultation and feedback for the provisions of the waiver application. Meetings were open to the public and were attended by individuals from provider professional organizations, state legislative representatives, consumer advocates and members of the public. Those in attendance were:

Name	Company
Alan Pruhs	Association for Utah Community Health Centers
Donna Gibbons	Association of Utah Community Health Centers
Gordon Crabtree	Chief Financial Officer, University of Utah Medical Center
Sheila Walsh-McDonald	Community Action Project
Kris Fawson	Community Representative
Allan Ainsworth	Fourth Street Clinic
Collin Davis	Healthy U
Representative Dean Sanpei	Legislator
Senator Dan Liljenquist	Legislator
Russell Frandsen	Legislative Fiscal Analyst
Mark Andrews	Legislative Research and General Counsel
Cathy Dupont	Legislative Research and General Counsel
Stan Smith	Molina Health Care
Byron Okutsu	Molina Health Care
Paul Muench	Molina Health Care
Karen Warren	Molina Health Care
Richard Rosenberg	Molina Health Care
R. Sanchez, MD	Molina Health Care
Kirsten Stewart	Salt Lake City Tribune
Jim Murray	Select Health
Jesse Liddell	Select Health
Todd Wood	Select Health
Sean Dunroe	Select Health
Kim Wirthlin	University of Utah Health Care
Bob Parker	Emergency Physicians Integrated Care, LLC
Michael Kelly	University of Utah Medical Center
Barb Viskochil	University of Utah Medical Center
Russ Elbel	University of Utah Health Plans
Dr. David Patton	Executive Director, Utah Dept. of Health
Rod Betit	Utah Health Care Association
Michelle McOmber	Utah Medical Association
Kevin Moffitt	Utah Valley Pediatrics
Lincoln Nehring	Voices for Utah Children
John Grima	Midtown CHC
Emily Sullivan	NAHDO

Name	Company
Denise Love	NAHDO
Doug Thomas	Department of Human Services/DSAMH
Korey Capozza	Health Insight
Michael Kelly	University of Utah
Allan Ainsworth	4th Street Clinic
Ed Dieringer	UAHC
Jason Cook	Voices for Utah Children
Shanie Scott	Utah Health Policy Project
Judi Hilman	Utah Health Policy Project
Emily Carlson	AUCH
Dave Gessel	Utah Hospital Association
Vicki Wilson	UUHC Health Plans
Doug Hasbrouck	Health Insight
Curt Peterson	Utah Medical Association
Lisa Fallert	Select Health
Danny Harns	AARP
Patrick Fleming	Salt Lake County
Kathy Konishi	Intermountain Health Care
Marshall McKinnon	Tanner Clinic
Ross Van Vranken	University of Utah
Barbara Munoz	Voices for Utah Children
Lisa Nichols	AUCH
Brent Clayton	Select Health
Amy Bingham	Molina
Adrian Corollo	Self
Lisa Maltess	Select Health
Robbie Morris	Select Health
Mark Brown	Select Health
Casey Hill	Utah Medical Association
Doug Burton	Select Health

B. Meeting Schedule and Topics

Date	Subject
April 6, 2011	Integrating the Pharmacy Benefit & Out of Network Payments
April 13, 2011	Cost Sharing
April 20, 2011	Capitated Rate Setting & Data Requirements
April 27, 2011	Client Incentives
May 4, 2011	Provide Assessment and UPL Preservation
May 11, 2011	Quality Assurances

Minutes from those meetings are available upon request.

Section VI Program Evaluation Proposal

Philosophy: This is a major initiative in changing the fundamental method for payment for services not only within the Medicaid program, but also will serve as the basis for significant reform in the Utah market more broadly. With that in mind, it is critical that we understand whether this approach can accomplish its public policy goals.

The two primary policy goals of this demonstration are: 1) Reduce the Growth in Costs and 2) Maintain Quality Services. We believe that this demonstration will slow the growth in costs without sacrificing quality of services to Medicaid patients.

Our approach to evaluating this demonstration program will rely primarily on quantitative analysis comparing the treatment groups in the waiver to appropriate control groups. We have consulted several experts in program evaluation and have come to the conclusion that the best approach to evaluating this program would be simple and rely on existing data sources, or data sources that will be readily available as part of the requirements of waiver participation.

This waiver will impact eligible residents in the four urban counties – Weber, Davis, Salt Lake, and Utah. This will define the study population. Because of the need to have a broad implementation of this waiver for full impact, it is not reasonable or desirable to do a randomized-control-trial method of testing and development. The question arises then as to what an appropriate comparison group would be.

In this situation and given our actual program goals, the most appropriate comparison would be to construct a pre/post program evaluation design. Fortunately, we have been collecting reliable data on this population for many years that can be used to establish a baseline for both the impact of cost and quality.

The following represents a summary and overview of our proposed plan for evaluating this demonstration as it relates to the two stated policy goals.

<u>Goal 1: Reduce the Growth in Costs</u>

Study Population: Waiver enrollees who live in the four-county area.

Comparison Group: Enrollees in managed care organizations living in the four-county area prior to the waiver going into effect.

Proposed Measure: Annual increase in per-member per-month costs. This measure would be constructed by analyzing actual costs to the Medicaid program on a per-member per-month basis. This should be calculated as the average monthly percentage change in costs.

Comparison Methodology: The proposed methodology for conducting the comparison would be in two phases. First, we would establish the time-trend of cost growth for the

comparison group (before the waiver takes effect). This would become the basis for the pre-program baseline. As a comparison, we would then monitor and analyze the time-trend of cost growth under the waiver programs. After allowing enough time for the program to have its desired impact, we would then use standard statistical modeling techniques to compare the pre and post program trends to determine whether there has been a meaningful decrease in the average annual rate of cost increase with the waiver in place.

Maintain Quality Services

Study Population: Waiver enrollees who live in the four-county area.

Comparison Group: Enrollees in managed care organizations living in the four-county area prior to the waiver going into effect.

Proposed Measure: Comparison of relevant set of HEDIS measures – For several years, we have been collecting HEDIS measures on Medicaid programs. We will continue to collect HEDIS data going forward. In fact, these measures will become a critical component in certification and possible reimbursement for participating organizations. We will establish a set of measures that indicate core quality measures for the Medicaid population.

Comparison Methodology: Once we have established a set of HEDIS measures that reflect general areas of quality of care that are relevant to the Medicaid population, we will use statistical modeling to compare these measures collected for the comparison group (pre-waiver) and the study population (post-waiver). We will look at specific measures of interest to the program that have been targeted as part of the contracting process, as well as other measures that indicate overall quality.

Conclusion: We cannot over-emphasize the importance of understanding whether this program can achieve the specified program goals. We hope to show that changing the payment methodology for Medicaid can guide the movement of the entire marketplace to a more value-oriented system. Because of the scope of this demonstration, we will not be able to use contemporaneous treatment and control groups. In any case, it may be more appropriate to look at the program's temporal impact on both cost and quality relative to our current managed care framework.

Section VII Consultation with the Indian Health Advisory Board

A. Introduction

Among other protections for Indian beneficiaries in Medicaid and CHIP, Section 5006 of the American Recovery and Reinvestment Act requires states to seek advice from federally recognized tribes regarding state plan amendments, demonstration requests, waivers or waiver renewals. Accordingly, before submitting a Medicaid or CHIP state plan amendment, demonstration request or application that directly affects Indian beneficiaries, the states must consult with Indian health programs and urban Indian organization.

Consultation

The Utah Department of Health and the federally recognized tribes of Utah developed a consultation policy that was effective November 2006. To comply with that policy and federal requirements, Utah's Division of Medicaid and Health Financing [DMHF] made a presentation to the Utah Indian Health Advisory Board [UIHAB] at its April 7, 2011 meeting. In preparation for that meeting, an overview of the Utah Accountable Care Organization (ACO) proposal, authorized under Senate Bill 180, was distributed to the Board by the Indian Health Liaison on March 22, 2011.

The presentation included an overview of the Medicaid Reform Proposal and focused on the provision that it will not change the way the Indian Health Programs bill for services delivered to American Indian Medicaid enrollees. At present, the Indian Health Programs bill the Medicaid agency directly rather than billing the Medicaid enrollee's health plan. This allows the American Indian Medicaid enrollees to have complete freedom of choice when seeking care from an Indian Health Program rather than a health plan provider. Although Utah is seeking to continue to operate under many of the principles of the 1915(b) Freedom of Choice Waiver, Utah Choice of Health Care Delivery Program authority, DMHF will continue to recognize the authority of the Indian Health Program and allow freedom of choice to all American Indians. This issue was thoroughly discussed during the UIHAB meeting to ensure the board members were aware that claims processing and payment will continue to be a function of the Medicaid agency and not the responsibility of the ACOs.

The Utah Indian Health Advisory Board has not yet requested additional consultation. The Medicaid agency will continue to provide information to UIHAB in the future as requested.

The agenda for the April 7, 2011 meeting of the UIHAB is on the following page.

Utah Indian Health Advisory Board Meeting
April 7, 2011
9:00 AM – 12:30 PM
Indian Walk-In Center
120 West 1300 South
Salt Lake City, Utah 84115
801-712-9346

Meeting called by:	Robin Troxell, Vice Chairperson
Type of meeting:	Monthly
Facilitator:	Melissa Zito
Note taker:	Gayle Coombs
Please Review:	Board minutes Feb & March, Medicaid SPA document(s), SB 180 Docs, Sample immunization posters.

AGENDA TOPICS

9:00 AM	Welcome & Introductions	Robin Troxell
9:15 AM	Approval Minutes	
	Committee Updates & Discussion	
	➢ Medicaid State Plan Amendments (SPA) & Rules	Craig Devashrayee
	➢ Medicaid 415 Project	Connie Higley
	➢ DWS Medicaid Eligibility	Sherra Lynn Westover
	➢ MCAC	David Ward
	➢ Pan Flu	Robin Troxell
	➢ CHIP Advisory Committee	Joan Perank
9:45 AM	IPC sites & Pharmacy Diversion issues	David Ward
10:00 AM	SB 180 Accountable Care Organization	Gail Rapp
10:30 AM	Molina Health Care; Traditional Medicine Coverage	Mary Ann White
11:00 AM	Immunization Program – DRAFT Poster	Nazrin Zandkarimi
11:15 AM	Cancer Program-update on colon screening	Genevieve Greely
11:15 AM	UIHAB Goals 1, 3, & 5 years; review & Discussion	ALL UIHAB Reps
11:45 AM	UDOH Update	Melissa Zito
	➢ UIHAB mtg. & 4 days vs. 5 day work week	Robin Troxell
	➢ CMS Site Visit in May; Cindy Smith	
	➢ Consultation Policy time line update	
	➢ SB33 Signing Ceremony; recommendations	
	➢ New Preparedness Trainer	
	➢ UTL's update	
12:30 PM	Adjorn THANK YOU IWIC FOR HOSTING MEETING	